Analyses of Parents’ Problems in Clinicians’ Assessments for the Children’s Court of Victoria on Child Protection Matters

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ABSTRACT

This research focused on analyses of expert clinicians’ assessments for child protection matters referred to the Children’s Court Clinic by the Children’s Court of Victoria in 2006-2007. Major aims were to examine the occurrence and co-occurrence of three forms of common parent problems; to analyse their association with clinicians’ identification of child-related issues and assessment issues and recommendations for placement decisions; and to examine the relationship between clinicians’ recommendations and subsequent court decisions about protection orders and the placement of children. The data were clinicians’ reports to the court that were analysed using content analytic techniques. The analyses focused on 138 families involving 250 children referred to the clinic by the court for expert psychosocial assessment.

Domestic violence, substance abuse and mental health problems contribute to parents’ ability to provide adequate care for children and are frequently present in families that come to attention of protection authorities. The research was framed by the significance of these parent problems in relation to two fundamental guiding principles that are prominent in child protection research and practice: ‘good enough parenting’ and ‘the best interests of the child’.

In two studies, content analysis of clinicians’ reports focused on distinctive patterns in clinicians’ mentions of domestic violence, substance abuse and mental health problems in relation to fathers and mothers, and on how these problems were related to clinicians’ mentions and concerns about child-related issues, assessment issues and recommendations.

Study 1 revealed 11 distinct patterns in the parent problems of the 250 children. These patterns in the parent problems were associated with child-related issues and clinicians’ placement recommendations. In families where parents were dealing with multiple and complex issues with substance abuse children were likely to be recommended
to kinship care, whereas a combination of father’s domestic violence and sexual abuse was related to out-of-home placements. Inconsistent with previous research, the results showed that family reunifications were related to families where both parents suffered from mental health problems. The least prevalent problems, mother’s domestic violence and father’s mental health, however, were associated with placements in parents’ care.

Study 2 showed that while the court agreed with about half the clinicians’ recommendations about protection orders and 73% of children’s placements, court orders were likely to be more intrusive and less likely to specify parents as potential carers of the children. The level of salience and concern about the parent problems was related to clinicians’ recommendations for placements and to court protection orders after the assessment. Court orders were more intrusive when the salience was high for mother’s mental health problems and for father’s substance abuse.

Overall, the combined findings from patterns and the individual parent problems highlight the inherent complexity of the families referred to the clinic. Patterns and various levels of concern related to the problems uniquely contribute to the clinicians’ recommendations and court decisions about child protection. Particularly mother’s mental health problems were prominent in the clinic and the court outcomes. These analyses shed light on the similarities and differences between recommendations and court orders. They also point to the unique contribution made by clinicians of the clinic, especially in problematic child protection matters.
DECLARATION

This is to certify that

(i) The thesis comprises my original work, except where indicated in the preface,

(ii) Due acknowledgment has been made in text to all other material used,

(iii) The thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies.

Signed ____________________ 29/10/2012. In Melbourne, Australia
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Chapter 1

INTRODUCTION AND RATIONALE FOR ANALYSES OF CLINICIANS’ REPORTS TO THE CHILDREN’S COURT OF VICTORIA

Clinicians of the Children’s Court Clinic of Victoria are asked to make recommendations to magistrates of the Children’s Court of Victoria on protection matters currently before the court. In most protection matters referred to the clinic, magistrates rely on the psychologists and psychiatrists of the clinic to identify and interpret the family problems and issues that bring a child before the court. The current research provides evidence of how clinicians identify and use the complex mix of case details to make assessments and recommendations on problematic child protection matters before the Children’s Court of Victoria.

The major aim of the research was to analyse clinicians’ assessment reports to the Court. Court clinicians working in the context of child protection commonly deal with families where parents have not been able to provide good enough care for their children (Budd, Poindexter, Felix, & Naik-Polan, 2001; Horwarth, 2005; Reder, Duncan, & Lucey, 1995). The specific aims were to identify the patterns in specific parents’ problems in clinicians’ assessments and recommendations that are known to have a negative impact on parenting capacity, including domestic violence, substance abuse and mental health problems (Bishop, Murphy, Hicks, Quinn, Lewis, Grace & Jellinek, 2000; Carter & Myers 2007; Gracia, 1995; Whipple & Webster-Stratton, 1991), and to examine to what extent the Court agrees with the clinicians’ recommendations in their decisions after they receive the assessment psychosocial reports.

Court-enforced child protection orders represent the most intrusive incidents in family life and are considered as a last resort when all other options have been
exhausted. When for example, parents resist supervision or intervention, and in the case of a child’s placement away from parents, any official action requires a legal authorisation (Australian Institute of Health and Welfare, 2008; Coate, 2001). Court authorities enforcing protective interventions often lack appropriate information and resources to have access to the child, family and environmental factors that impact on protective concerns. In Australia and many other common-law countries, the ‘best interests of the child’ is the criterion through which authorities use to make decisions about a child’s life (Children, Youth and Families Act, [CYFA] 2005; Van Zyl, 1997). However, there is no one definition or one set of guidelines defining what the best interests entail, adding to the complexity of decision-making processes. The information presented to the court is often processed quickly and courtroom testimonies show only a fraction of the child-parent interaction as well as individual functioning. Despite of these limitations, magistrates and judges have to make decisions quickly given the overflowing load and pressure children’s courts are under.

Due to the significant rise in care and protection numbers (Sheehan, 2001), there is an increasing need for more research (Richardson, Higgins, & Bromfield, 2005) to map out the individual and systemic functioning of families facing protective concerns. To date, there has been very little systematic analysis of the processes of court ordered clinical assessments and recommendations for children under protection applications. It seems that the present challenge is to research the processes involved in current child protection decision-making (Sheehan, 2001). Notwithstanding the need to learn more about the functioning of families facing protective concerns, no previous studies have systematically examined assessment reports on families and their children in the psycholegal context of child protection.
CHILD PROTECTION – WHO’S RESPONSIBILITY?

Family-based Child Protection

Families have the primary responsibility for caring for children and preparing them for life in developmental, social and educational contexts. A child is born into this world without an innate ability to protect itself. This means that primary caretakers, usually parents, have a biological duty to protect and care for the child. However, child abuse and neglect are most likely to occur in the family rather than in any other environment a child is in interaction with (English, 1998).

This means that the responsibility transfers to the state in cases where the child is at risk of abuse or neglect in the family environment (Australian Law Reform Commission and the Human Rights and Equal Opportunity Commission, 1997). In Australia, legislative responsibility to control the interaction between the state and the family is distributed between the federal legislation and the states and territories within a range of government departments. In this sense, the legislation works as an authority in decisions on whether the family meets its child-related responsibilities to the standards set by the state. Nevertheless, the interaction between the state and the family appears symbiotic in relation to bringing up children. Securing the family’s status in law arises from a normative interest of the family as the primary social unit for the stability and continuity of family relationships. In effect, the family and the state are together responsible for fostering the well-being and development of children.

State-based Child Protection

The responsibility of the state to protect children arises from the principle of parens patriae which empowers the state to act as a parent of last resort when parents are incapable of providing adequate care for their children (Carney, 1983; Weiss, 1990). While child protection services are based on a principle that the best care of children is
usually within their family unit, the child’s individual right to protection and well-being
crises above this principle (Sheehan, 2001). However, what constitutes a failure to
provide adequate care varies between institutions and protective systems. For example,
each state in Australia specifies protective issues according to its own legislation. In
terms of the larger issues, there is likely to be considerable overlap. Less overlap,
however, may occur because of the interpretative frameworks used by, for example,
government departments and parent advocacy organisations.

The Victorian statutory child protection system operates under CYFA replacing,
in April 2007, the Children and Young Persons Act (CYPA, 1989). The legislation
allows the state to intervene in family life, laying down conditions for supervision and
monitoring of parental care and for removing the child from parents in extreme case of
alleged abuse and neglect. The legislation provides a structured and legally contestable
interface between the family and the state, often causing tension between the supportive
and the authoritative functions of the state (Humphreys, 2007). The line between
intervening into family life and protecting children seems very fine in the context of
child welfare. In securing the protection of children the state has a statutory role and an
authority to act as a legal parent (Masson, 2008). Its different decisions may be
interpreted as unnecessary intrusion in some families (e.g., in families with disabled
parents; Llewellyn, McConnell, & Ferronato, 2003).

Children’s Courts

When community intervention by government authorities is not adequate to
provide protection for children within their families, state responsibility for the children
is designated to the courts. Any statutory removals of children from their biological
family units, for example, need to be ordered by the court. Thus, child protection cases
brought to the court by child protection authorities represent one of the state’s most
serious and coercive interventions in the lives of children and families. Therefore, such a petition is only justified if the child cannot be otherwise protected.

In 2006-2007, 18% of child protection reports in Victoria were substantiated for court proceedings and child protection applications were granted for approximately half of the substantiated cases brought to the Children's Court of Victoria (Department of Human Services, 2008). The Children's Court is a specialist court with two divisions to deal with matters relating to children. Child protection matters are dealt with in the Family Division of the Children’s Court and juvenile matters within the Criminal Division and in some suburban courts. In many countries, Family Courts are heavily involved with child protection matters. In Victoria, the Federal Family Court deals with granting divorces and associated matters such as child residence and contact arrangements, and not as consistently as the Children’s Court with child protection matters.

When a child is removed from the family, parental rights are overridden to secure the child’s right to a safe environment. The flip side is what Walsh (2009) describes as securing parental rights to raise children as well as the child’s right to live with their biological parents. From a service point of view, the first one focuses more on removing the child from the family and finding an appropriate placement for the child, the latter on the families’ abilities to protect the child’s rights to develop in safe care.

These contrasting objectives build an ambiguous platform to work towards the child’s best interests. In the Victorian model, the new CYFA has consciously shifted the balance away from service responses focused on minimal intervention into family life, to an approach to assessment, planning and action directed by the protection and promotion of healthy child development. The CYFA, states: “For the purposes of this Act the best interest of the child must always be paramount” (s.10) placing the rights
and well-being of the child as the central focus of the legislation and the one that must inform all the other processes in the child protection system (Department of Human Services, 2007). The best interest of the child is a guiding principle in many national child protection systems (e.g., Van Zyl, 1997) but what it constitutes remains open to interpretation.

The legislation (CYFA, 2005), for instance, directs the court to remove the child from his/her family 'if there is an unacceptable risk of harm to the child' (s. 87[1] [j]), as a result of sexual or physical abuse, emotional harm or threat of harm to a child's emotional development. The definition for what constitutes ‘an unacceptable risk of harm’ is not set up in the legislation. The interpretation is left for magistrates to judge (Martyn & Levine, 1998). Given that magistrates come from a legal background and do not necessarily have training or knowledge about child development, attachment and parenting practices, the task of making informed decisions of where the child should be placed or what support services should be provided for the child and family may be complicated. A commonly accepted model of child abuse describes an interaction between emotionally conflicted parents, vulnerable children and social stress, with episodes of abuse occurring during periods of heightened tension in these relationships (Reder & Duncan, 1997). Therefore, it is reasonable to expect that judicial officers of children’s courts can benefit from affiliation with and input from both child and adult mental health services. For example, in cases of emotional abuse, legal decision-makers often struggle, because such cases require them to make judgments about parental behaviour and the quality of parent–child relationships rather than a determination about an observed act of harm to a child (Glaser, 2002).

CYFA was specifically aimed at developing more therapeutic and child-centred models of care and to facilitate better care and understanding of vulnerable children and
their families. In most ambiguous or problematic child protection matters, magistrates refer cases for a clinical assessment and opinion in order to assist them make an informed decision (as reported by magistrates in the preliminary study; Suomi & Lawrence, 2008). The courtroom provides a limited environment to make comprehensive assessment of the child’s well-being or family processes and functioning. In this scenario, the magistrates’ decision-making benefits from further evaluation of the family situation.

**Clinicians’ Role in Court Protection Matters**

The children’s court clinic fulfils a unique function in child protection in Victoria. The psychologists and psychiatrists of the clinic provide the court with psychosocial assessments of children and families who are before the court in both child protection and criminal matters. Clinicians of the children’s court clinic have a special role in the state’s discharge of its responsibility to provide protection for vulnerable children. They make their assessments and judgments within a particular, court-focused perspective. In protection matters, the clinicians assess the parents and children and sometimes extended family members. They make expert interpretations of the problems and issues affecting the child’s life and well-being and make recommendations to the court about arrangements and services that may best serve the child’s circumstances and needs.

These assessments become an important source of information for guiding the decision processes of the Court on problematic protection matters. They represent a small proportion of all protection matters before the court (less than 10%). The Court considers these cases problematic enough to seek out psychological assessments and recommendations. These matters usually involve families with complex arrays of problems and matters that are being contested in court.
The provision of a court clinic that provides independent and impartial evidence to serve service to the court in a state protection system is unique to Victoria and New South Wales (as established by a telephone survey of state court systems, in 2008). However, the New South Wales model is to some extent different from the Victorian Clinic. Rather than having a central metropolitan office where all clients are seen for assessments, the New South Wales model has a core team of staff located in Sydney and a number of accredited clinicians located across the state. The Victorian model is more centralised with an aim to undertake all assessments at one clinic.

**The Victorian Children’s Court Clinic**

The Children Court of Victoria is a separate branch of the Magistrates’ Court, in line with all states and territories. The role of its judges and magistrates is to hear evidence and decide whether a child is in a need of protection and the decision reached has to be based on the burden of proof principles known as the balance of probabilities (Martyn & Levine, 1998). Magistrates make an assessment based on evidence supplied by protective workers, witnesses, families and other professionals involved in the child’s welfare. In Martyn and Levine’s study (1998), the magistrates stressed some of the difficulties that arise from magistrates’ lack of formal training in family welfare and psychology, although, the decisions they make are often based as much on psychological considerations as well as on legal criteria. For instance, all magistrates had significant concerns about removing the child from the parents’ care. This was due to their personal belief of preserving the family unit as well as from poor outcomes of alternative care that fail to provide continuity.

The court clinic fulfils an advisory role in child protection matters before the children’s court. The court clinic clinicians provide expert psychological and psychiatric assessments to aid magistrates’ decision-making about problematic, ambiguous, or
complex cases, as revealed in a group discussion with magistrates (as reported in the next section). In 2007, 18% of 38,675 child protection reports proceeded to the Children’s Court of Victoria. The court clinic receives a referral on 3% of these cases (Australian Institute of Health and Welfare, 2008). However, since there has been no research on magistrates’ or the courts’ use of the services of specialised court-attached clinics, a small preliminary study was carried out as part of this research (Suomi & Lawrence, 2010).

**Preliminary Study: Magistrates’ Perspectives on Referring Child Protection Matters to the Children’s Court Clinic**

Before analysing clinicians’ recommendations about protection matters to Children’s Court Magistrates, it was important to ask why magistrates refer children and their families to the clinic. A group discussion with magistrates focused on why they order clinical assessments for particular protection matters and their bases for making such referrals was requested.

The discussion was a useful starting place for the empirical work, because the clinicians’ recommendations are specifically addressed to the magistrates to inform and assist them in their decision-making. This preliminary study was framed within Lawrence’s ongoing analyses of court processes (Lawrence, Higgins, Levine, & Laster, 2010). The aim was to use the magistrates’ comments as a foundation for the major study on clinicians’ psychological assessments.

The Court Liaison Officer organised a group meeting with four magistrates at the Children’s Court. The procedure involved a free-flowing group interview for an hour. One researcher conducted the discussion and another made notes. The researchers compared notes after the meeting.

Three main questions were asked from the magistrates and were followed-up in
any of their comments: (1) what kind of cases do magistrates refer to the court clinic – what cases do they typically refer and what kind of cases would they never refer and why? (2) what are the magistrates looking for in their referrals to the clinic? (3) what are the magistrates’ expectations on clinic outcomes usually and exceptionally?

The magistrates specified eight main reasons to refer a protective matter to the clinic:

1. **Assessment for particular psychological issues** (e.g., attachment). In most cases, the role of the Department of Human Services is ‘prosecuting’ the parents and they do not have clinicians to assess the families.

2. **Independence**, referring to completely independent assessments by the court clinicians who are responsible directly to the court. This is particularly important for the family.

3. **The calibre and quality of the reports – the clinic engages ‘experts’**. The clinic director organises the right match for the child from the expert lists.

4. **Looking for the best person to care for the child.**

5. **The assessment can reduce contest** in many cases where DHS and the family both are petitioning for guardianship of the child.

6. **Funding issues** – legal aid does not fund independent reports or provide financial help for assessments.

7. **Clarification in a clinical context** of the people involved in protection matters (e.g., the significance of extended family members). DHS only investigates protective issues – not the people involved in the actual issues.

8. **Occasionally the assessment ‘gives the child a voice’**, i.e. makes them heard if the child is not legally represented.

The magistrates explained how they saw the function of the court clinic as
important for mapping out the child and family circumstance in problematic cases. A request for an assessment is mostly ordered in relation to a protective matter that is contested in court, or where the details of family arrangements are unclear or ambiguous, or where issues for children and their families are particularly complex and in need of expert psychological insights.

The comments of these four magistrates were used as a basis for searching for the type of information the clinicians identify as important in protection matters, their specification of the defining assessment issues, and their consideration of child and family issues and problems in making recommendations to the Court. These preliminary results specified the context for the analyses of the psychosocial assessment reports.

In sum, it seems that the Children’s Court Clinic of Victoria fulfils a unique function in the child protection system by providing independent evidence in matters where the courts need further information about how to best protect the child. Those providing evidence are expert psychologists and psychiatrists who have specialised skills and experience in court-ordered clinical assessments. As far as was possible to determine, however, there are no systematic analyses that have examined how these assessments, particularly focusing on the common problems of parents, contribute to court decisions about the child’s best interests.

**ORGANISATION OF THESIS**

In overview, this chapter has laid out a rationale and background for the current research: the responsibilities of the family and the state for child protection, and how the court and clinic function within those areas of responsibility. It is noted that the protection matters discussed in this thesis are a subset of severe and problematic cases that have been brought to the court by the department of human services and subsequently referred by the court to the clinic for assessment and recommendations.
Chapter 2, then, addresses the focus for content-analytic analyses of clinicians’ reports to the court of their assessments and recommendations about protective matters for 250 children. The review in Chapter 2 addresses the most common problems of parents present in the majority of court-enforced child protection matters. It reviews the current theory and research about the role of parents and the ways parental domestic violence, substance abuse and mental health problems contribute to protective matters in relationships between the parent and the child.

Chapter 3 provides an account of factors that impact on clinicians’ assessments, and recommendations in matters where families have failed to protect their child. It specifically addresses how clinicians use the assessment information in making recommendations to the courts. Chapter 3 also introduces the content analytical approach for the analyses, concluding with a set of research questions addressed in the two studies involved in the present research.

For Study 1, Chapter 4 introduces the methodology about the patterns in the parent problems clinicians mentioned in their reports. Chapter 5 reports the development of 11 cluster groups based on the three types of parent problem identified for fathers and mothers. The results of Chapter 6 illustrate how the 11 patterns are associated with other case characteristics and clinicians’ recommendations about children’s placements.

Study 2 reported in Chapter 7 builds on the analyses of Study 1 by deepening the analyses of parent problems and how the Court followed up clinicians’ recommendations in their decisions after the assessment. The results of Study 2 specifically encompass the level of clinicians’ concerns about parent problems as related to clinic recommendations and court decisions about placements and court protection orders.
Chapter 8 draws on the empirical findings from Study 1 and Study 2 in relation to background theory and research in order to demonstrate the significance of parent problems in clinicians’ assessments and how they contribute to court decisions about child protection. The unique contribution of a specialised court clinic to court decisions is discussed in relation to the guiding principles of ‘good enough parenting’ and the ‘best interests of the child’, with directions for future research.
Chapter 2

THE PROBLEMS OF PARENTS IN CHILD PROTECTION:
DOMESTIC VIOLENCE, SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS

This chapter examines a major focus in children’s court clinicians’ assessments: the problems experienced by biological parents. Specific attention is on how parental problems contribute to protective concerns, especially in assessments and recommendations made by courts and clinicians.

Parents’ personal well-being is closely linked to their parenting capacity and the kind of care they are able to provide for their children. In families who come to the attention of protective services, the parenting standards have fallen outside the range of adequate care (Horwarth, 2005).

This analysis and review begins with a working concept of ‘good enough parenting’ that clinicians commonly use as a criterion in assessments of child protection matters (e.g., Budd, et al., 2001; Reder et al., 1995). It then moves to a description of parent practices in situations where parenting is no longer good enough and a protective intervention is warranted. This account of specific issues commonly present in families subjected to child protection interventions focuses on three frequently observed parent problems in child protection matters: domestic violence, substance abuse, and mental health problems (Bishop et al., 2000; Carter & Myers 2007; Gracia, 1995; Whipple & Webster-Stratton, 1991). It emphasises both their independent and combined impact on the safety and wellbeing of children.

Good Enough Parenting in Child Protection

It is a widely held view that parents with serious personal problems are not able to provide good enough care for their children, a criterion that is widely used in
assessments of parenting capacity (e.g., Azar & Wolfe, 2002; Benjet, Azar, & Kuersten-Hogan, 2003; Reder, Duncan & Lucey, 2003). It follows, then, that court clinicians usually look for a minimal standard of parental care rather than an optimal one in their assessments of the families referred to them by the court (Butler, Atkinson, Magnatta, & Hood, 1995; Otto & Heilbrun, 2002). Little is known, however, about parental problems with respect to the good enough criterion in their assessments and recommendations to children’s courts.

When parents are overcome by their own needs or stress, it becomes difficult to put the needs of their children first. The way children experience their different environments is greatly influenced by parenting behaviours and characteristics (Brooks-Gunn & Markman, 2005; Reder et al., 2003). Child protection practice and policy recognise this influence and traditionally concentrate on the parent as the target of state protective interventions (Budd et al., 2001).

Clinical assessments of child protection matters involve establishing these specific competencies of parents to meet the safety and developmental needs of the child (Azar & Benjet, 1994; Azar & Wolfe, 1998; Budd & Holdsworth, 1996; Donald & Jureidini, 2004). The standard of good enough parenting practices, then, is often invoked in making recommendations to the court (Reder & Lucey, 1995).

Ideally, parents facilitate the development of children by being available, predictable, responsive, and by providing a structured and caring home environment (Pianta, Egeland, & Sroufe, 1990). Good enough parenting indicates the minimum amount of care needed to not place a child at risk of significant harm (Reder, et al. 2003). It requires, for example, the parents to consistently set boundaries, provide nurturance and love and put the child’s needs first (Azar & Cote, 2002; Budd, 2005; Edwards 1995). Since the quality of parenting is reflected in the adults’ capacity to
recognise such needs, the essence of good enough parenting is to provide adequate care and attention for each child in a developmentally and emotionally appropriate manner (Donald & Jureidini, 2004).

In child protection matters, a similar term used specifically in assessments of parenting capacity is “minimal parenting standard” (Budd et al., 2001, p. 93). It requires parents to satisfy minimal levels of care to meet the challenges posed by each child’s phase of development and temperament within the family context. The main question is whether parents in their particular circumstances are able to respond to the needs of their children well enough to maintain the children’s safety. While parents’ personal problems do not automatically lead to, they are often associated with parenting behaviours that may place a child at risk (e.g., Leventhal, Jacobsen, Miller, & Quintana, 2004; Magura & Laudet, 1996; Miller, Smyth, & Mudar, 1999; Seeman, 1998).

Donald and Jureidini (2004) highlighted the connection between parent problems parents’ inabilities to keep their children safe. They argued that good enough parenting is at risk when parents are severely depressed and subjected to domestic violence or incapacitating substance use. Scott and Swain (2002) noted that parents with substance use, serious mental illness or other problems constitute the majority of child protection cases in Australia and that these particular parent problems are often deemed threshold criteria for child protection measures. Azar et al. (1994) studied the life skills, familial history, and access to support and other resources of parents with mental health and substance abuse problems. Impediments in these areas were related to clinicians’ decisions of ‘not-good-enough parenting’ and subsequent child protection proceedings.

Children’s individual needs vary in domains of physical, emotional and social development (Azar & Wolfe, 1998). Adequate care for one child may not be good enough for another. Even in dysfunctional environments, the parent may have the
capacity to provide adequate care for the child, depending on parent and child characteristics as well as their mutual relationship (Benjet & Azar, 2003).

Although good enough parenting is a frequently invoked concept in child protection assessments, its markers are not clearly defined. Consequently, one major challenge child protection authorities face in their assessments is a lack of consensus about good enough parenting in families where parents’ personal problems warrant protective intervention. Even less is known about how clinicians and judicial officers interpret parents’ capacities to function in relation to the problems parents frequently display in child protection matters.

**The Role of Parents in Child Protection**

Reasons for not good enough parenting in child protection matters are usually embedded in the parents’ inability to ensure a safe environment due to their own problems. These may lead to more risky, or even bad enough, parenting that is seen as warranting protective intervention by the state (Cooper 1985; Newman, Day, & Warden, 2004).

While some developmental models (e.g., Patterson, 1982; Patterson, Bank, Stoolmiller, 1990; Rubin, Stewart, & Chen, 1995) suggest that parents and children have equal roles in their interactions and subsequent family outcomes, others (Belsky, Glistrap, & Rovine, 1984; Belsky, Crnic, & Woodworth, 1995; Meyers, 1999) have asserted that parenting practices are mainly determined by the parents’ personal resources. Belsky et al. (1984; 1995), for example, proposed that the personal resources of the parent (i.e. mental health, personality) have a greater impact on parenting behaviours, whereas child and contextual characteristics have a more indirect influence on parenting, moderated by parent characteristics and susceptibility to stress.
In families that fail to protect their children to the extent that a state intervention is called upon, the problems are commonly related to parents’ personal health and lifestyle issues (Bishop, Murphy, Hicks, Quinn, Lewis, Grace & Jellinek, 2000; Carter & Myers 2007; Gracia, 1995; Whipple & Webster-Stratton, 1991). However, few protection cases involve harm as a direct result of these issues (Scott & Swain, 2002).

One of the major tasks of a specialised court clinic is therefore to assess the situational factors related to the problems of parents at both the individual level and the level of the wider community. In protection matters, courts are interested in how these problems interact with other exacerbating factors and individual characteristics, and whether they warrant a court ordered intervention. Azar and colleagues (Azar, Lauretti & Loding, 1998; Benjet, et al., 2003), for example, propose a functional-contextual approach to court child protection assessments that addresses both micro- and macro-level interactions in the family. They focused on parents’ functional parenting capacity, including assessments of their strengths and weaknesses, in caring for a specific child in particular environments. This holistic framework consequently informs the court of the kinds of practical supports the family may need to bring parenting practices up to a good enough level.

In fulfilling their main task, providing evidence to the court, clinicians are required to focus on particular aspects about parents and their capacity to meet the child’s needs. The information about the parents is therefore crucial in court decisions about the children’s placement and about the level of court-ordered intervention the family requires to bring the parenting capacity to a good enough level. In many cases that come before court, however, the parents are overwhelmed by their own problems that contribute to the protective concerns.
PARENT PROBLEMS IN CHILD PROTECTION

Three types of parent problems (domestic violence, substance abuse and mental health issues) are identified as often present in child protection matters in clinical references (Aza & Benjet, 1994; Azar, Benjet, Fuhrmann, & Cavallaro, 1995; Azar, 1996; McConnell & Llewellyn, 2002), in legal writings (Australian Family Law Council, 2009; Johnston, Lee, Olesen, & Walters, 2005) and in the popular media (Butler, 2011; Funnell, 2010). Very little is understood, however, about how these problems are used and interpreted in assessments of families where children’s safety or well-being is in question. Particularly, there is a call for investigations of how the problems of parents interact and their combined impact on child well-being in assessments of child protection concerns.

Victorian studies (Brown & Glaun, 1999; Department of Human Services, 2008; Sheehan, 2001), for example, have shown that the main predisposing factors in child neglect and abuse arise from interactions between adverse living environments (e.g., poverty) and parental attributes. In state child protection services (Department of Human Services, 2002), the key underlying features that lead to contact with protective authorities were poverty, parental substance abuse, mental health issues, and single parenthood. There are, however, multiple ways to understand the impact of parent problems on the ability to provide good enough care for children. For example, a mother suffering from acute psychosis could be expected to struggle in providing a safe home for an infant with special needs, when she could be better at managing a healthy, placid baby with an easy temperament. If such a mother lives with a violent partner and is in fear, she is likely to be even less appropriately attentive to a fractious baby. It is important to examine the combined effects of the three common parent problems in relation to child factors in court clinic assessments. In order to illustrate the ways the
problems of parents contribute to clinicians’ assessments and recommendations, the
next section analyses each of the three problems and their co-occurrences in child
protection matters.

DOMESTIC VIOLENCE

Identifying Domestic Violence

The widely adopted UN account for identifying domestic violence asserts that:
The expertise of relevant professionals, including psychologists and counsellors,
advocates and service providers for complainants or survivors of violence, and
academics should be utilized to determine whether behaviour constitutes
violence (UN, 2010, p. 25).

The same UN guidelines refer to physical, sexual or mental harm and usually see
these as gender-based acts again women and children. It seems that domestic violence is
almost always seen as perpetrated by an adult against a partner or a child. This does not
mean that in child protection matters domestic violence cannot take other forms, e.g.,
sibling violence or violence between extended family members.

Despite continued reference to domestic violence in clinical practice and policy,
there is no universal definition. ‘Domestic violence’ and ‘family violence’ are often
used interchangeably to refer to a range of hostile behaviours that occur between family
members. Their use is not consistent. For example, the Australian government, in
specific work with children and women who are exposed to violence refers to ‘domestic
violence’ to cover physical violence, sexual abuse, emotional abuse, intimidation,
economic deprivation or threats of violence (Tually, Faulkner, Cutler, & Slatte, 2008).
The Victorian Specialist Family Violence Services (Department of Human Services,
2006), however, uses ‘family violence’ in reference to a nearly identical list of
behaviours. It is reasonable, then, to follow Stanko and colleagues (Stanko, Crisp, Hale,
by using “domestic violence” as a general descriptor of intra-
familial violence (e.g., Stanko et al., 1998; UNICEF, 2000). Some of the studies
reviewed in this chapter use the term family violence. The general focus, however, is on
abusive, intra-familial behaviors. The range of aggressive behaviours included in these
descriptors varies according to the context in which it is used, particularly in legal
contexts.

**Legal accounts of domestic violence.** According to US *Federal Family
Violence Prevention and Services Act*, § 10421, domestic violence is an act against a
relative or co-resident that results in physical injury or fear of injury. Under Australian
law, domestic violence refers to behaviours by a heterosexual partner resulting in injury,
imimidation or harassment, damage to property, indecent behaviour or a threat of these
acts (Alexander, 1993).

Victoria's recently amended *Children and Young Persons Act 2005 (CYFA)*,
under which the child protection system operates does not specifically identify domestic
violence among the grounds for protection. The sense nevertheless, is clear. Under
section 162(1) of the *CYFA*, a child is considered to be in need of protection if the child
has suffered or is likely to suffer significant harm as a result of physical injury and the
child’s parents have not protected the child from harm.

Family violence, however, is singled out in the Victorian *Family Violence
Protection Act 2008*, s 5(1) and this is used in decisions about intervention orders at the
Children’s Court. It involves any behaviour towards a family member that is physically,
sexually, emotionally, psychologically or economically abusive or that, in any way,
controls or dominates the family member. The Act also covers the exposure of children
to any of these behaviours.
Neither domestic nor family violence is a fixed term. It is the task of protection authorities to investigate each individual case on its own merits in deciding whether domestic violence has contributed to significant harm and warrants court protection interventions.

The Prevalence of Domestic Violence

Domestic violence is present in nearly half of child protection matters (Bagshaw & Chung, 2001; Humphreys, 2007; McIntosh, 2003; Worth & Merting, 1997). Both adults and children are victims in at least one third and up to 60% of families experiencing domestic violence (Appel & Holden, 1998; Edleson, 1999; Jaffe & Wolfe, 1990). This magnitude of domestic violence in the protection system can be understood in comparison to its rates in the community. A few prevalence studies have reported lifetime rates of domestic violence ranging from 12% to 46% in developed countries (Freund, Bak, & Blackhall, 1996; Johnson & Elliot, 1997; Marais, de Villiers, Mollers, & Stein, 1999).

The rates of intimate partner violence seem to vary between 1 and 17%, and lifetime victimisation between 8 and 36% in US, UK, and Australia, depending on the acts of violence that were identified in each study (Australian Bureau of Statistics, 2007; Mirres-Black, 1999; Mouzos & Makkai, 2004; Tjaden & Thoennes, 2000; Wilt & Olson, 1996). In between 85% and 90% of cases of intimate partner violence, children are also present (Cleave, Unell, & Aldgate, 1999; Queensland Domestic Taskforce, 1998).

Hussey, Chang and Kotch (2006) reported that 28% of children in the US have experienced physical abuse. MacMillan et al. (1997) revealed that a history of child physical abuse was reported more often by males (31%) than females (21%). Recent Australian studies (Australian Bureau of Statistics, 2007; Cohen et al., 2006; Mazza,
Dennerstein, Garamszegi, & Dudley, 2001; Price-Robertson, Smart & Bromfield, 2010; Rosenman & Rodgers, 2004) show that the child abuse rates range from 5% to 18%, depending on the definitions and methodology used to calculate the rates.

One form of maltreatment often coalesces with other forms of abuse. In between 30% to 60% of families where domestic violence is a factor, direct child abuse also occurs (Australian Bureau of Statistics, 2007; Appel & Holden, 1998; Edleson, 1999; Indermaur, 2001; Laing & Bobic, 2002). In an Australian study (Goddard & Hiller, 1993), 55% of children who witnessed domestic violence also were targets of direct physical abuse and 40% were also sexually abused.

**Impact of Domestic Violence on Children**

Violence, even when not directly aimed at the child, is linked to threats to children’s well-being, including their own aggressive response, depression, future substance abuse as well as feelings of insecurity and disturbed attachment (e.g., Worth & Mertin, 1997; National Research Council, 1993). Given that domestic violence is frequently addressed in child protection cases, a specific matter of concern is the strong link between domestic violence and adverse child outcomes including serious psychopathologies. McIntosh (2003), for instance, argued that the level of trauma from witnessing spousal violence impacts on all levels of a child’s functioning, including psychological and emotional disturbances, disrupted social schemas and intergenerational transference of violent behaviours.

**Childhood conduct disorders.** Children exposed to domestic violence generally have more conduct disorders and behavior problems than children from nonviolent homes (Christopoulos, 1986; Jaffe, 1986; Martinez-Tortey, Bogat, von Eye, & Levendosvky 2009). Webster-Stratton and Dahl (1995) pointed out, for example, associations between child behavior problems and domestic violence. They especially
identified disproportionately severe punishment coupled with inconsistent parenting. Inconsistent parenting and a fear of punishment is likely to elicit a child’s negative conduct as a response to the adult behaviour. This could be interpreted as an example of Patterson and Yoerger’s (1993) vicious cycles. In a cyclical effect, a child’s conduct problems are linked to aggressive parent reactions, with the child’s negative behaviours progressively increasing. Not only may a child develop problems as a result of domestic violence, but abusive parenting can also be exacerbated by the child’s difficult behaviour or high emotional needs (Patterson & Yoerger, 1993).

From this perspective, the development of childhood antisocial behaviours and conduct disorders can be understood on the basis of dynamic systems interacting with each other (Patterson, 2002; Granic & Patterson, 2006). Reciprocally, for example, parents’ overly severe punishment may reinforce the child’s patterns of poor behaviour and vice versa. These vicious cycles, as Patterson and Yoerger (1993) point out, can continue on and escalate through the child’s development.

**Childhood mood disorders.** Spaccarelli, Sandler and Roosa (1994), for example, found that violence against the mother in a girl’s childhood was highly associated with ongoing depression in their adolescence. In comparison to non-abused children, a study of Danish children (Christoferssen & DePantifilis, 2009) found more depression, eating disorders and suicidal tendencies in abused children. Ackerman, Newton, McPherson, Jones and Dykman (1998) studied the prevalence of mood disorders in a sample of 204 sexually and physically abused children. Abused girls exhibited more mood disorders, whereas boys were more likely to display externalising problems. Children who were abused by males had more diagnoses of mood problems than those abused by females. The possible outcomes are complex and severe.
Child emotional trauma, behavioural and developmental difficulties consequently contribute to parents’ difficulties in caring for the child that may lead to further problems in the parent-child interaction over time (Bagshaw & Chung 2001; Buckley, Holt & Whelan, 2007; Lamb & Lewis, 2005; McCrae, 2009; Sachs-Ericsson, Kendall-Tackett, & Hernandez, 2007; Velleman, Templeton, Reuber, Klein, & Moesgen, 2008). This strong link between adverse outcomes and exposure to domestic violence seems to persist throughout life.

**Impact of Domestic Violence on Parenting**

Domestic violence has a long-term impact on the victims of abuse, including their parenting skills that consequently translates to concerns for children’s safety and later negative outcomes (Evans, 2007). Specific cognitive processes of parents as well as contextual family factors are often linked to families where domestic violence is present.

**Cognitive processes.** Azar, Making-Byrd and Nix (2005) argued that in adverse family environments and when dealing with multiple sources of stress, parents’ cognitive functioning generates the risk of violence to children. Indirectly, the dysfunctions in parents’ cognitions, including unrealistic expectations about the child’s abilities and poor problem-solving skills, further exacerbate stress, increasing the likelihood of child abuse. Similarly, Seng and Prinz (2008) attributed child abuse to the cyclical nature of dysfunctional parenting schemas, (e.g., tendency to accuse the child of aggressive behaviours, unrealistic expectations) and poor problem-solving skills, low perceived control and high perceived stress. These cognitive factors were also related to parents’ greater negative arousal and lower empathy in situations when the child was distressed.
**Family context.** Levendosky and Graham-Bermann (2001) proposed an ecological contextual model to understand the impact of domestic violence on families. Contextual factors related to violent family environments (e.g., poverty, low education, high unemployment) contributed to parenting behaviours and child adjustment problems. Specifically, lack of social support coupled with mothers’ negative functioning was associated with dysfunctional parenting.

The risk of continuing violence with their own children and partners seems to be higher for victims who also exhibit other co-morbid conditions such as alcohol abuse and antisocial behaviour (Laing & Bobic, 2002). Not all abused children, however, grow up to be abusive adults. While maltreated parents exhibit significantly poorer parenting styles and suffer from other risk factors, those who are able to break the abuse cycle are more likely to have other supports (financial and social) (Dixon, Browne, & Hamilton-Giachritsis, 2005). Jacobvitz and Sroufe (1988) and Egeland (1991) found that parents who broke the cycle of abuse were more likely to live in secure home environments, show greater emotional stability and display fewer signs of depression and anxiety.

**Domestic Violence in Child Protection**

It is reasonable, then, to expect that domestic violence, because of its persistence and the level of harm it promotes, will be frequently linked to families who come to the attention of protective services. Domestic violence seems to be present in at least half of child protection matters (Bagshaw & Chung 2001; Humphreys, 2007; McIntosh, 2003; Worth & Merting, 1997). It tends to co-occur with other family issues including poverty and substance abuse (Sheehan 2001; Gracia, 1995; Whipple & Webster-Stratton, 1991). For example, large-scale studies in the US have shown that 30% to 50% of child protection matters include domestic violence (Magen & Conroy, 1998; National...
In an Australian study (Irwin, Waugh, & Wilkinson, 1998), domestic violence was the most common reason for protective intervention, being more prevalent than other parent conditions such as substance abuse and mental health problems.

In summary, children in families where domestic violence occurs are adversely influenced by the interplay between parent characteristics and the family context rather than by individual psychopathology. While the relationship between domestic violence and child specific problems appears to be strongly related to parent-child interactions, other factors in the family context (particularly lack of social support coupled with parents’ personal problems and cognitive distortions), are important to consider when domestic violence is a concern for child wellbeing.

**SUBSTANCE ABUSE**

**Identifying Substance Abuse**

Parents’ substance abuse constitutes protective concerns in many accounts of protection matters. A widely used diagnostic manual (*DSM-IV*; American Psychiatric Association, 2000) identifies the core features of substance abuse that are also used for the purposes of the current study. These core features include maladaptive and continued patterns of drinking or drug use. The manual recognises that the use of both alcohol and drugs can elicit substance abuse disorders, with alcohol constituting most of the substance abuse disorders (Pirkola, Poikolainen, Lonnqvist, 2006; Teesson, Hall, Lynskey, & Degenhardt, 2000).

**The Prevalence of Substance Abuse**

The scale and impact of alcohol and drug use on families have been examined in large population based community studies. Depending on the methodology used, the prevalence of lifetime substance use disorder is somewhere between 5% and 20% of the
population (Kessler, Dupont, Berglund, & Wittchen, 2005; Jacobi, Wittchen, Holting, Pfister, Muller, & Lieb, 2004). An Australian national study (Australian Bureau of Statistics, 2008) reported the 12-month prevalence rate of substance abuse as 8%, with men twice as likely to have substance use disorders (11% compared with 5% of women). Significantly more, around half, of all the matters subjected to child protection interventions involve substance abusing parents (Forrester, 2000; Gorin, 2002; Hayden, 2004).

**Impact of Substance Abuse on Children**

One major reason why parents’ substance abuse poses a threat to child safety and protection is its negative effects on children. Children of substance abusers, for example, show more difficult temperaments, are more impulsive, are at higher risk for depression and anxiety and have higher rates of both emotional and behavioural problems (Christensen & Bilenberg, 2000; Chatterji & Markowitz, 2001; Leonard, Das Eiden, Wong, Zucker, Puttler, & Fitzgerald, 2000; Weissman et al. 1999; Wilens, Biederman, Kiely, Bredin, & Spencer, 1995). There is also an elevated risk of child abuse or neglect in substance abusing families (Ammerman, Kolko, Kirisci, Blackson, & Dawes, 1999; Magura & Laudet, 1996; Williams-Petersen et al., 1994).

**Physical harm.** Children whose parents abuse drugs or alcohol are twice as likely to be physically or sexually abused (Walsh et al., 2002). Semidei, Radel and Nolan (2001), for example, found that for families involved with child welfare agencies, around 30% of parents were under the influence of substances when child abuse took place. Different types of substances seem to be linked to specific patterns of abuse. Famularo, Kinscherff and Fenton (1992), for instance, found that alcohol abuse was related to physical maltreatment and cocaine abuse to sexual maltreatment.
Emotional harm and neglect. Some evidence suggests that emotional harm and neglect, rather than physical harm, are the main forms of protective concerns resulting from parental substance abuse. Parental substance abuse may also increase the vulnerability of such a child to victimisation by others outside the family through poor parental supervision (Drake & Zuravin, 1998; Finkelhor, Hotaling, Lewis, & Smith 1990). Children of parents with substance abuse problems are younger than other children in the child protection system, and more likely to be the victims of severe and chronic neglect in families that also have other complex problems (US Department of Health and Human Services, 1999). For example, Hayden’s (2004) study of 412 child protection cases in England showed that emotional abuse and exposure to domestic violence were more frequently associated with parental substance abuse than direct physical and sexual abuse. Dawe at al. (2006) suggested that parental alcohol abuse increases the risk of emotional harm and neglect through other problems including inadequate food, clothing or medical care and exposure to domestic violence.

Impact of Substance Abuse on Parenting

Substance abuse has been found to have an adverse impact on family functioning (Bijur, Kurzon, Overpeck, & Scheidt, 1992). Thus, parental substance abuse may either directly or indirectly place a child at higher risk of maltreatment. One reason children from substance abusing families are at risk of serious maltreatment is the link to the consequences of substance abuse. These include physical discomfort, withdrawal symptoms, and having to cope with financial and psychological problems (Dawe, Harnett, Staiger & Dadds, 2000; Klee, 1998). Ammerman et al. (1999), for example, suggested that substance abuse is related to low frustration tolerance, increased anger reactivity, disinhibition of aggressive impulses, and poor decision-making skills. Other research (The National Clearinghouse on Child Abuse and Neglect
Information, 1993) has attributed the impact on family functioning to families’ limited financial resources to provide for child well-being, and to parents spending time seeking drugs, and being unable to monitor or engage with their children. Substance abusing parents may also leave dangerous substances available for consumption or expose children to potentially dangerous strangers in the home environment.

**Specific parenting behaviours.** Drug or alcohol problems may decrease the ability to parent effectively or increase the level of punitiveness toward children (Miller, Smyth, & Mudar, 1999). Particularly, substance-using women are likely to use aggressive tactics with family members (Magura & Laudet, 1996; Miller et al., 1999). Substance abusing mothers also tend to rely more on negative reinforcement strategies, severe disciplinary practices and authoritarian involvement in managing their children’s behaviour (Bauman & Dougherty, 1983; Hien & Honeymann, 2000; Wellisch & Steinberg, 1980). Thus, it may be that in some cases the cyclical nature of child behavioural difficulties and parental substance abuse leads to direct child abuse.

Kandel (1990) found that mothers who used drugs in their teens showed less parental monitoring and lower levels of warmth than mothers without a history of substance abuse. Unexpectedly, fathers’ involvement with drugs was associated with positive parenting. Drug abusing fathers exhibited less punitive discipline and more involvement in activities with the child. In contrast, however, Tarter, Blackson, Martin, Leber and Moss (1993) studied disciplinary practices of 46 substance abusing fathers of 10-12 year-old boys. The quality of parental discipline for substance abusing fathers was poorer in comparison to the control group. Unfortunately, there are not many studies on the impact of substance abuse on fathers’ parenting capacity (McMahon & Rounsaville, 2002).
Substance Abuse in Child Protection

Since parents’ substance abuse places children at immediate risk of abuse and neglect (Chaffin, Kelleher, & Hollenberg, 1996; Jaudes, Ekwo, & Van Voorhis, 1995; Magura, Laudet, Kang, & Whitney, 1999), it is not surprising that children whose parents experience drug and alcohol problems are consistently overrepresented in the child protection system (Murphy et al., 1991; Brown & Anderson, 1991; Famularo et al., 1992; Locke & Newcomb, 2003).

While alcohol is a more common concern, drug abuse seems to be disproportionately represented in child protection cases. Studies (Forrester, 2000; Gorin, 2002; Hayden, 2004) from the US, UK and Australia show that parents’ substance abuse is present in around 50 to 60 percent of protection matters. Half of these are drug related problems. In many cases, parents’ alcohol and drug abuse co-occur, a pattern that seems to be strongly associated with long-standing involvement with social services and removal of the children (Hayden, 2004).

The rates of parents’ substance abuse seem to progressively increase from community child protection cases to more serious protection matters that warrant court intervention. In court protection matters, the rates are between 57% and 78% which is substantially higher than in community child protection services (Cleaver et al., 1999; Leek, 2004; Hayden & Johnson, 2000). More often than not, children in out-of home care placements also have experienced parental substance abuse and the effects of that substance abuse are varied (Famularo et al., 1992; Young, 1998; Forrester, 2000).

**Substance abuse and out of home placements.** Parental substance abuse appears to be strongly related to removal of children from their biological families (Besinger, Garland, Litrownik, & Landsverk, 1999; Delfabbro, King, & Barber, 2010; Marcenko, Kemp, & Larson, 2000), and placement in kinship care (Beeman, Kim, &
Bullerdick, 2000). It even relates to difficulties in the stability of placements (Tracy, 1994). In matters where the child is reunited with their substance abusing parents, a substantial number are removed again due to recurring protective issues related to their return to alcohol and drugs (English, Marshall, Brummel, & Orme, 1999; Sagatun-Edwards, Saylor, & Shifflett, 1995; Wolock & Magura, 1996).

There is some particularly discouraging evidence that parents’ recovery after a court-ordered alcohol and drug treatment does not increase reunification rates, as demonstrated Gregoire and Schultz’s (2001) study of 167 parents with substance abuse problems. They speculated that court orders usually take place only when protective concerns have reached a point where the child is at significant risk and where severe substance abuse usually indicates a poor prognosis. Comparison of court and noncourt ordered rehabilitation may have resulted in different outcomes but those data are not available.

In fact, one reason for high levels of home placement and low levels of reunification in substance abusing families may be related to stigma associated with the effects of substance abuse. People in protective systems have come to not trust substance abusing parents. D’Andrade (2010) found that in comparison to mental illness and domestic violence issues, parents suffering from substance dependency were least likely to obey court orders or to benefit from parenting classes aimed at assisting with the reunification process. Similarly, parents with substance abuse problems were more likely to reject court-ordered services and subsequently have children removed from their care (Murphy et al., 1991).

In summary, parental alcohol and drug abuse constitute a major concern for child well-being and are also critical issues in decisions about the child’s placement. Negative effects seem to be mediated through maladaptive parenting practices.
associated with the effects of drug and alcohol abuse. It appears that multiple pathways place child development at risk through associated aggressive or disinhibited parenting behaviours and environmental deprivation in families where substance abuse in present.

MENTAL HEALTH

Identifying Mental Health Problems

A range of mental health issues is also known to contribute to parents’ ability to provide a safe environment for healthy child development. In the present research, the main categories of mental illnesses as described in the DSM-IV (American Psychological Association, 2000) are used in analysing parental mental health problems in the clinic assessments. These categories include mood, anxiety, psychotic and personality disorders, excluding any substance-related mental health disorders. They also cover any symptoms consistent with the diagnoses that may be otherwise insufficient to meet the diagnostic criteria. This allows the examination of acute deterioration in parents’ mental health that may contribute to the protective capacity of the family environment.

In a legal context, ‘mental illness’ is used to refer to persons who are considered as patients under the state and territory Mental Health Acts (McDermott & Carter, 1995). Mental illness is defined as a range of diagnosable illnesses resulting in significant impairment in day-to-day functioning (Australian Health Ministers, 1998). The term mental illness is identified in the Victorian Mental Health Act 1986, section 8(1A) as a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

However, inconsistent use of terms such as ‘mental illness’, ‘mental health problems’ and ‘mental disorder’, complicates the interpretation of studies. In child protection assessments, both chronic as well as temporary disturbances to parents’
mental health may affect the safety of the child. The present research refers to ‘mental health problems’ in referring to both the long and short term impact of parents’ mental health.

**Prevalence of Mental Health Problems**

In Australia, nearly one in five adults is diagnosed with current mental health disorders (Andrews, Henderson & Hall, 1999; Australian Bureau of Statistics, 2007). Anxiety disorder is the most common (10% to 14%) followed by mood disorder (6%). Lifetime prevalence in Australia for any mental health disorder in 2007 was 45%. Much lower rates were found in the US (Teesson et al., 2000), whereby only 23% had a lifetime prevalence rate for any mental disorder excluding substance use disorders. Furthermore, between 21% and 23% of Australian children have at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2005).

**Impact of Parental Mental Health Problems on Children**

While it is reasonable to suggest that parent mental illness constitutes a risk factor to child well-being, there is no single interpretation of the way mental illnesses manifest as inadequate or harmful parenting practices. The specific nature of the condition may not always be accessible to courts or other professionals. Unlike domestic violence and substance abuse, for instance, the impact of parents’ mental illness on child development is more often detected only in later life (Stanley, Tomison, & Pocock, 2003).

Maternal depression, in particular, is often linked to childhood psychopathologies including child attention deficit disorder, conduct disorder and emotional adjustment problems (Beardslee & MacMillan, 1993; Leschied et al., 2003; Rutter, 1985). Beardslee and MacMillan (1993), for example, found that children of mentally ill parents exhibited more difficulties in general functioning, interpersonal
relationships and attachment. By the age of 20, children with a mentally ill parent had a 40% chance of experiencing an episode of major depression. That relationship grew even stronger when parents also experienced marital difficulties, parenting problems, and more severe mood disorders.

The evidence of the impact on children is, however, inconsistent. Although children of mentally ill parents are at risk for adverse outcomes, many develop normally (Melton, Petrila, Poythress, & Slobogin, 2007). A large body of evidence, for example, shows that children of severely depressed mothers can establish positive attachments and achieve developmentally normal outcomes (Cohn & Campbell, 1992; Cohn, Matias, Tronick, Connell & Lyons-Ruth, 1986; DeMulder & Radke-Yarrow, 1991). Some studies of depressed mothers, however, have revealed impaired patterns of parent-child interactions and subsequent negative outcomes (Cohn et al., 1986; Field, Healy, Goldstein, & Guthertz, 1990; Jameson, Gelfland, Kulcsarm & Teti, 1997; Moehler, Brunner, Wiebel, Reck, & Resch, 2006). This inconsistent evidence points to the complex relationship between parental mental health and child outcomes that play a role in clinicians’ assessments of these families.

**Impact of Mental Health Problems on Parenting**

In many instances parents’ mental illness poses challenges to adequate parenting by interacting with additional, co-occurring factors. Social isolation (Aldridge & Becker, 2003), poverty, unemployment and poor physical health (Gould, 2006), for example, are common correlates. Parent-child interaction and parenting skills can be particularly impaired by the effects of mental illness and associated family circumstances (Appleby & Dickens, 1993; Goodman & Brumley, 1990; Jacobsen & Miller, 1998; Leventhal et al., 2004; Seeman, 1998). Downey and Coyne (1990), for example, suggest that both parental depression and child problems are related to other
factors in the family context, such as marital conflict or stress. There is no simple way to understand the functional and contextual implications of parents’ mental illness for their children’s well-being.

Maternal depression, especially, has been associated with issues in child cognitive, emotional and psychosocial development (Cummings & Davies, 1994; Kiernan & Huerta, 2008; Kurstjens & Wolke, 2001; Murray, Cooper, Wilson, & Romanuk, 2003). Depression can affect the parent’s ability to engage with the child appropriately by providing important developmental experiences (Murray & Cooper, 2003). Depressed mothers, for example, are less competent and less responsive to their children leading to disruptions in parent-child relationship (Tebes, Kaufinan, Adnopoz, & Racusin, 2001; Miller, Warner, Wickramaratne, & Weissman, 1999). These disruptions, specifically in early infancy play a major role in adverse developmental outcomes (Cummings & Davies, 1994).

**Parental Mental Health in Child Protection**

Due to the adverse impact of parents’ mental health problems on child development, it is not surprising that it is consistently associated with concerns about child safety in the child protection system (Gibbons, Conroy, & Bell, 1995; Glaser & Prior 1998; Llewellyn et al., 2003; Walsh et al., 2002). Studies in the UK (Gibbons et al., 1995; Thoburn, Lewis, & Shemmings, 1995) show that between 13% and 31% of child protection matters involved a parent with mental health problems. In Australia, around one third of neglected children have a parent with a diagnosed mental illness (Glaser & Prior, 1998).

Maternal depression, in particular, has been strongly linked to child protection concerns (Sheppard, 1996). Lahey, Waldman and McBurnett (1999), for example,
found that abusive mothers were more likely to be clinically depressed and to use fewer positive and more negative interactions with their children than non-abusive mothers.

**In court protection matters.** Mental health problems are commonly present in court protection matters (Booth, Booth, & McConnell, 2005; Taylor et al., 1991). In a set of studies undertaken at the Victorian Children’s Court (Brown & Glaun, 1999; Sheehan, 2001; Sheehan & Levine, 2005), around 30% of contested child protection matters at the Children’s Court of Victoria involved parents whose mental health problems were a significant factor in protective concerns. In another study of court files, parental psychiatric disability was present in 22% of court child protection matters (Llewellyn et al., 2003).

Other studies show that up to 78% of children placed in out of home placements by courts have at least one parent with a mental illness (Booth et al., 2005; Miller & Finnerty, 1996; Quinton & Rutter, 1984). Taylor and colleagues (1991) found that parents diagnosed with mood disorders were most likely to have their children permanently removed from their care. The relationship persisted even after accounting for the parents’ compliance with court orders.

**Interactions with the legal system.** Parents’ mental health problems can also cause a disadvantage when interacting with welfare and justice systems and practitioners (McConnell et al., 2006). A lack of specialised, professional, knowledge from the courts can lead to bias against parents who suffer from mental illness; thus children are sometimes subsequently removed from parents without evidence of child abuse or neglect (Baer, Sampson, Barr, Connor, & Streissguth, 2003).

It is clear in the literature that parents with mental health problems are significantly over-represented in statutory child protection proceedings and these problems seem to account for some of the court decisions and final outcomes. While
children of mentally ill parents are at increased risk of emotional and behavioural problems, there is less clear evidence of the immediate impact of parents’ mental health on child developmental outcomes, in comparison to parents’ domestic violence and substance abuse problems.

The impact of individual domestic violence, substance abuse and mental health problems are commonly under scrutiny in child protection assessments where good enough parenting is in question. There are, however, other factors that coincide with these problems and impact on the functional and contextual manifestations of related parenting behaviours. A parent with a mood disorder, for example, may resort to drug abuse for relief from their illness and this may subsequently lead to neglecting the care of their children. Other parents may only experience one type of problem that can be readily improved with focused interventions. The patterns of the parents’ co-occurring personal problems are the focus of the final section of this chapter, which reviews how these patterns in parent problems emerge in families where a child’s well-being is a concern.

**CO-OCCURRENCE OF PARENTAL DOMESTIC VIOLENCE, SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS IN CHILD PROTECTION**

Life adversities do not occur in a vacuum and child protection issues are complex and cumulative (Bromfield & Miller, 2007). Family issues, particularly those involving domestic violence, substance abuse and mental health problems, tend to occur in clusters (Music, 2011). It is important, then, to examine patterns of co-occurring parent problems and their significance in child protection matters. Clinicians are called on to assess the dynamic nature of a family’s problems as they occur in the family’s experience. For example, alcohol and drug use appears to exacerbate aggressive behaviors in the family; hence, substance abuse often provokes domestic violence
Domestic violence is also associated with increased risk of developing substance abuse problems (Clark & Foy, 2000) and mental health difficulties (Holtzworth-Munroe, Smutzler, & Sandin, 1997), including depression and suicidality (Leone, Johnson, Chan, & Lloyd, 2004; Stark & Flitcraft, 1995).

Understandably then, there is a call for more systematic evidence for the subtypes of families affected by domestic violence and other problem behaviours, how these subtypes are interpreted in relation to each other and how they are linked to good enough or not good enough parenting practices in important decisions about child protection.

**Co-Occurring Parent Problems in Child Protection**

Complex life adversities often accumulate into difficulties that have a detrimental impact on the parents’ capacity to provide adequate care for their child (Bishop et al., 2000; Carter & Myers 2007; Department of Human Services, 2002; Gracia, 1995; Whipple & Webster-Stratton, 1991). Substance abuse and mental health issues, for example, share many environmental factors including biological as well as social variables such as disadvantaged neighbourhoods, unemployment, and lack of social support in the family environment that contribute to the relationship between substance abuse and mental health (Fergusson, Horwood, & Ridder, 2007; Kendler, Neale, MacLean, Heath, Eaves, & Kessler, 1993; True, Xian, Scherrer, Madden, Bucholz, Heath, Eisen, Lyons, Goldberg, & Tsuang, 1999). It is reasonable to expect that different patterns of parents’ substance abuse and mental health problems are also present in child protection matters and impact on parenting behaviours.
Co-Occurring Mental Health Problems and Substance Abuse

Some evidence exists on the co-occurrence of maternal mental health and substance abuse in families subjected to concerns about child safety and wellbeing. Substance abuse often occurs in a context of emotional, social and economic deprivation (Sheridan, 1995) including domestic violence, mental illness, financial disadvantage and transience (Semidei, Radel, & Nolan, 2001). Carter and Myers (2007), for example, found that a combination of parental substance abuse and mental health problems were twice as likely to occur in families where child abuse was present in comparison to non-abusing families.

Maternal depression, in particular, has been linked to negative impacts on children. Dawe, Harnett and Frye (2008), for example, found that maternal depression with substance abuse had more adverse impact on child developmental outcomes in comparison to anxiety or psychotic disorders with substance abuse. In comparison to depressed mothers, those suffering from both depression and substance dependence show significantly higher levels of difficulty in social relationships, general health and in responding to their children’s needs as they are overwhelmed by their own needs (Woodcock & Sheppard, 2002).

Substance abuse and mental health may also spiral situations into instances of domestic violence, particularly in families where other stress factors are present. Robins and Regier (1991) found that substance abuse disorders were strongly associated with the onset of child abuse and neglect, whereas depression was a strong risk factor for physical abuse. When parents have co-occurring intellectual and psychiatric disabilities with substance abuse problems, they are also at high risk of having their children removed from their care (McConnell et al., 2006).
Co-occurrences with Domestic Violence

Clinicians, in their assessments of child protection matters, are required to address the specific context in which particular parent problems evolve (Azar et al., 1998). It is reasonable to expect that cumulative risks in the environment, for example, lead to worse child outcomes. For instance, households where domestic violence occurs often include high levels of other developmental risk factors such as poverty and parental substance abuse (Fantuzzo & Mohr, 1999).

Violent home environments are also linked to harsh, punitive, parenting practices and other forms of violence that interfere with normal child development and lead to generally negative outcomes (Edleson, 1999; Fantuzzo & Mohr, 1999; Margolin & Gordis, 2000; Wolak & Finkelhor, 1998).

Appleyard and colleagues (2005) proposed a linear model of risk factors: the more co-occurring risks (i.e., child maltreatment, inter-parental violence, family disruption, low socioeconomic status, and high parental stress) the more adjustment difficulties children experience in later life. Indeed, in comparison to non-abusive parents, abusive parents were more affected by poor parental psychological adjustment and parenting practices, child behavior problems, social isolation, higher levels of stress and socioeconomic disadvantage (Whipple & Webster-Stratton, 1991; Gracia, 1995).

Romero, Donohue and Hill (2006) proposed that there are both direct and indirect links between parents’ substance abuse and domestic violence. For example, a direct association follows when a cocaine addicted mother lashes out at a child or their partner while intoxicated. Direct impact is also involved when the mother self-medicates with drugs to eliminate stress from violent behaviour. An indirect impact is a by-product of the direct effects, manifested over time. For example, a mother’s
increased irritability due to lack of sleep and nutrition from the cocaine abuse leads to heightened stress levels and may result in further instances of abuse.

**Co-occurrence of Family and Social Factors**

The well-being of children has been related to the social support available to the family (Runyan et al., 1998). Not only the immediate family network but also wider social support may contribute to the ability of parents to provide adequate care for their children. Mothers of children in care, for example, have reported fewer current close relationships with family members and friends in comparison to control groups (Quinton & Rutter, 1984). A strong social network can, indeed, compensate for the lack of care that parents are able to provide in families experiencing complex problems and is also an important factor in court assessments of parenting (Brown, 1999). For example, a parent with a mental illness may be able to provide adequate care for a child in a supportive partnership, or within a strong extended family network, but not as a single parent.

There is little evidence about how a child’s age and sibling constellations are related to protective concerns or decisions. It is expected, however, that a child’s age and number of siblings exacerbate the parenting burden where a greater number of younger children require more of the parents’ daily capacity than older children. An early study (Quinton & Rutter, 1984) on child protection records, for example, showed that 60% of the children in out of home care had at least three siblings compared to 20% of children living at home. Younger children are also more likely to be physically neglected than older children, given their higher care needs (Carter & Myers, 2007). More evidence on the child’s age, gender, and sibling constellations in child protection matters is, however, needed.
Although a considerable amount of evidence points to the high prevalence and co-occurrence of parental domestic violence, substance abuse and mental health in child protection matters, there is a lack of systematic evidence about the patterns of co-occurrence of these problems. Lack of evidence about the parental problems, commonly present in the families, translates into a limited understanding about how to best provide the child and their families with a safe environment.

Summary

Clinicians are required to consider multiple factors when making decisions about the protection of a child. Clinicians process and interpret the family characteristics and functional parenting capacities against the good enough parenting standard. While parents’ domestic violence, substance abuse, and mental health problems are widely known to reduce their capacity to provide adequate care, they do not provide direct evidence of ‘bad enough’ parenting. The problems form a complex web of factors that impact on parents’ abilities to care for their children. It is then reasonable to assume that parents with these problems are also over-represented in the child protection system.

Despite substantial evidence of the presence of these specific parental problems in the child protection system, there is a specific need for systematic evidence for how the problems of fathers and mothers coincide, and how the sets of parental problems are interpreted in decisions against the standard of good enough parenting. Specifically, how these family circumstances are considered and interpreted in expert clinicians’ assessments at the interface of psychology and law have not been previously studied. The current research aims examine how clinicians make assessments about specific parent problems through their psycholegal perspectives on family problems. The current chapter addressed the content of clinical assessments consistently present in child protection assessments, the problems of parents. Court decisions about child protection
are made not only regarding parental contributions to child development and well-being, but also considering the relevant child protection legislation. The following chapter examines how expert clinicians assess and make recommendations about family problems within the psycholegal framework. It particularly focuses on different aspects of the framework in which court clinicians consider and interpret the parent problems in protection matters.
Chapter 3

CLINICAL ASSESSMENTS AND RECOMMENDATIONS IN CHILD PROTECTION MATTERS – A CONTENT-ANALYTICAL APPROACH

The focus of this chapter is on clinical assessments for court purposes with a major focus on psychologists’ and psychiatrists’ assessment reports about child protection matters referred by the court. The chapter concentrates specifically on the assessments and recommendations made to the court by expert clinicians, and how clinic recommendations for court orders and placement decisions relate, not only to the case characteristics, but also to how their recommendations are followed up at the court.

The chapter is structured in three sections. It begins with a description of the specific role expert clinicians play in court child protection decisions. The specific factors court clinicians are influenced by, in assessments of court child protection matters are also addressed: the legal decision-making principles and clinical guidelines. Then, an account of clinicians’ use of assessment information is described in the following section of the chapter with a review of existing, although limited, research on factors associated with decisions about children’s placements. The chapter concludes with a systematic approach to analysing the content and clinician use of assessment information in making recommendations to the court, involving the research questions for the current study that are addressed in Study 1 and Study 2.

CLINICAL ASSESSMENTS IN CHILD PROTECTION

As discussed in Chapter 2, assessments of family functioning and parenting capacity are common in child protection (e.g., Reder, Duncan, & Lucey, 2003). They occur at numerous points in the history of a case, and are made by practitioners in a number of professional roles (e.g., social worker, protection worker, medical practitioner, psychologist, psychiatrist). The court most commonly requests clinic
assistance concerning families where problems are complex, and where there is ambiguous or contradictory information about the protective concerns (Brown, 1999). Clinicians attached to court clinics are expected to provide impartial and independent evidence on families with compounding problems and difficulties.

Yet, there is surprisingly little systematic analysis of the assessments and recommendations that clinicians provide to the court. Some studies have examined assessments by social workers (e.g., Scott, 1995; McConnell, et al., 2006; Rossi, Schuerman, & Budde, 1999). These studies tend to focus on the role of child protection workers in earlier stages of child protection proceedings and not specifically in court. These assessments are usually made prior to court involvement or after final court decisions.

The present research follows in the tradition of forensic research (Hecker & Steinberg, 2002; Jamieson et al., 1999) and clinical research (Welsh & Lyons, 2001) by analysing the content of actual reports produced by court clinicians. These expert reports usually address family functioning in relation to the child’s developmental needs (Hynan, 2003).

The key factors in assessments of parenting capacity rest upon the specification of parental factors influencing their capacity. They also rest upon the identification of the needs of the child within their particular family context. The assessments involve establishing whether the child’s needs are being met, addressing the impact of any identified parenting problems on the child’s functioning and development, and considering whether improvement in the situation is possible (Reder et al., 2003). While the psychosocial needs of the child are important, the legal framework in which clinicians interpret the assessment information about parents’ capacities to meet the
needs of children also guides court assessments. As discussed in Chapter 2, a major concern is the adequacy of the parenting – if the parenting is good enough.

As proposed by Azar and colleagues (Azar et al., 1998; Benjet et al., 2003), three major considerations shape the ways expert clinicians make assessments to courts in child protection matters: (1) the legal framework that sets up the clinicians’ approach to assessment; (2) clinical guidelines involved in the expert testimonies that court clinicians are subject to in everyday work; and (3) the cognitive tasks involved in assessing case-related information drawn from multiple sources in complex matters (e.g., reports from multiple professionals in a case file, family interviews, clinical observations, psychological testing).

Clinical assessments and reports have been studied in several ways (Budd et al., 2001; Butler, Atkinson, Magnatta, & Hood, 1995; Pellegrin & Wagner, 1990). These previous studies have mainly focused on aspects of assessments about placement recommendations, or how the courts’ decisions agree with clinicians’ recommendations, or on the structure of court ordered clinical assessments. No known studies have holistically addressed the patterns of compounding parental problems in families, how they are used and interpreted in clinicians’ assessments and recommendations, and the ways these reports are used at the court.

**COURTS’ USE OF PSYCHOLOGICAL ASSESSMENTS**

The usefulness of specialised court-attached clinics stems from their function as expert responses to critical questions about family and child welfare that can affect the court final decisions (Medoff, 2003; Sheehan & Levine, 2005). To provide evidence of families’ specific needs, expert mental health professionals make relevant information available for the courts in the form of psychosocial family assessments. These clinical assessments can provide informative and individualised markers of parenting capacity
and skills in circumstances where a child is at risk of significant emotional or physical harm (Budd et al., 2001; Brown, 1999). Such markers of functional parenting ability, for example, involve various types of strengths and weaknesses as well as manifestations of psychopathology that play a role in court final decisions (e.g., Gould & Stahl, 2000; Grisso, 2003, Otto et al., 2000).

Clinical assessments are expected to provide an informed, impartial perspective that informs decision-making in court final decisions (Butler et al., 1995; Melton et al., 2007). In some cases, the clinicians are also required to testify as expert witnesses by using the evaluation data that are gathered with impartiality and with reliable methods that reflect the knowledge and experience of psychology (APA, 1999; Daubert v. Merrell Dow Pharmaceuticals, Inc, 1993).

The role of psychological assessments in child protection matters is examined in a handful of empirical studies of how courts follow up psychological recommendations in child protection decisions. Previous research, for example, shows that between 62% and 73% of expert clinicians’ recommendations are followed up at the court (Butler et al., 1995; Jamieson et al., 1999). The degree to which courts agree with the recommendations seems to be related to how comprehensively the clinicians have explained the basis for the recommendations in their reports (Hecker & Steinberg, 2002).

There is, however, little empirical evidence on the content and method in clinical assessments in court child protection contexts, or on how the courts actually use the assessments in making decisions about the protection of the child (Budd et al., 2001; Bauer & Barnett, 2001).
Clinical Assessments as Expert Evidence

Psychologists’ assessments commonly include information about the child, specifically about whether a child was abused or neglected, has emotional or behavioural problems, and about his or her relationship with parents. According to the American Psychological Association (APA, 1999), such assessments should make recommendations for mental health interventions, and the placement of the child and access with parents.

The American Psychological Association’s Guidelines for Psychological Evaluations in Child Protection Matters (APA, 1999) state that:

The role of psychologists who conduct child protection evaluations is that of a professional expert who strives to maintain an unbiased, impartial approach to the evaluation (p. 13).

Only a small fraction of court protection matters are typically assessed at a court-attached clinic. In Australia in 2008, for example, specialised court clinicians operated only in Victoria and in New South Wales. Families referred to the clinic by the court are commonly in the ‘grey area’, involving children who might be able safely live with their parents if the family receives quality input and services (Brown, 1999). This reflects the invocation of good enough parenting in court child protection assessments (Azar & Benjet, 1994; Azar et al., 1998; Budd & Holdsworth, 1996; Donald & Jureidini, 2004). Thus, in some cases, the court requires clinical expert advice to understand the aspects of families that can be improved to enable a child to grow up safely.

Clinical Expertise

There is an ongoing debate about the relative value of expert clinical assessments. One extensive line of early research (Ackerman, Brodsky, & Zapf, 2005;
Berman & Berman, 1984; Camerer & Johnson, 1991; Dawes, 1994; Garb, 1998; Pain & Sharpley, 1989; Rowe & Wright, 2001) on clinical assessments shows that experts do not always perform better than less well-trained individuals. Other studies (Alexander & Judy, 1988; Benner, Hooper-Kyriakidis, & Stannard, 1999; Crook, 2001; Chi, Glaser, & Farr, 1988) reveal that experts, through training and experience, outperform novices but mainly in their own domain, in which they have developed meaningful heuristics that organise complicated patterns of knowledge. This allows experts to solve problems quickly with fewer errors, perhaps reflecting the importance of domain-specific knowledge (Alexander & Judy, 1999). More recent research (Falvey, Bray, & Hebert, 2005) also shows that experts perform better in considering more complex interactions between case characteristics when making recommendations for appropriate interventions and treatment planning.

Expert clinicians are accustomed to nonlinear, contextual processing in weighing and interpreting co-occurring symptoms (Ganzach, 2001). In comparison to less experienced novices, for example, experts use more domain-specific, theory-based reasoning (Gaultney, Bjorklund, & Schneider, 1992; Gobet & Simon, 1998) and give causal explanations (Kim & Ahn, 2002; Wakefield, Kirk, Pottick, & Hsieh, 1999). They also use their own idiosyncratic theories based on empirical experience (Medin, 1989; Welsh & Lyons, 2001).

In a child protection context, the specialised skills of expert clinicians stem from their ability to interpret and provide detailed and functional evidence of the manifestations of risk in protection matters (Benjet et al., 2003).

Family issues, particularly those involving domestic violence, substance abuse and mental health problems, are complex and may be cumulative (Bromfield & Miller, 2007; Music, 2011). Court clinicians are required, then, to examine these patterns of
family issues and their significance. The value of specific psychological and psychiatric expertise in decision-making lies in this holistic and contextual understanding of, both the individual, and interactive contextual family factors. It also lies in the specific court-related focus of a dedicated clinic. There, legal principles can be invoked, and indeed, become part of the expert's specialised knowledge.

**Legal Principles for Assessments**

While the techniques and approaches used in assessments are based on psychologists’ knowledge of psychopathology and human behaviour, what clinicians assess and describe to courts is also defined and identified by law (Otto & Borum, 2004). Consequently, a major factor contributing to clinical assessments of court child protection matters is a thorough understanding of the relevant legislation (Azar et al., 1998; Brown, 1999). The reference to legal principles in interpreting and weighing the case information in reports to the court is also an aspect of this activity that differs from the practical applications of other fields of clinical psychology.

There are two major principles in child protection matters that are commonly called upon in court clinical child protection assessments. These are ‘good enough parenting’ and the ‘best interests of the child’ (Butler et al., 1995; Gould, 1998). Good enough parenting was considered in Chapter 2, whereas the best interests of the child, specifically invoked by the protection law, are addressed next.

**A major principle: the best interests of the child.** In child protection legislation and in assessments for court purposes, the best interests of the child is treated as the overall criterion for all decisions made about children (*Children, Youth and Families Act 2005, [CYFA]; Peters, 1996*). Although the criterion has been criticised as vague and undefined (Van Zyl, 1997), it guides all assessments and protective decisions concerning the health and well-being of the child. However, the lack of an empirically
Driven identification of the specific factors underlying this standard is a concern. When considering best interests in decisions about child welfare, the challenge lies in merging both legal and psychological viewpoints in interpretations of what is actually in the best interests of a particular child.

A previous Victorian CYPA 1989 stated that protection of the child should be the primary aim (s.87; s.119). It also highlighted that intervention should be the least intrusive to protect the child, and where possible, the family should be supported to care for its child without legal intervention or with minimal possible intervention (CYPA, s.87).

The current CYFA 2005 in effect from April 2007, however, promotes more directly the safety of the child by implementing the best interests principle (s. 10). While the Act is mindful about the family as a core unit of society (s.11), it also regards the child’s safety and healthy development as the overarching priority in making assessments and recommendations about protective services and interventions.

The best interests principle is further clarified in CYFA (s.17), which highlights the importance of preserving and strengthening the child’s relationship with the family, even when the parents are not fully able to care for their child. The legislation is clear about the need to assist the family’s provision of care where possible. In situations where a child’s removal is warranted, it is a priority to reunite the child with their family as soon as practicable. However, what generates confusion is that the CYFA (s.10) also states that the child’s safety is always the primary concern. In effect, the focus on permanency, stability and attachment is considered secondary to this basic need. The task of clinicians and courts, then, is to interpret each family context and parent’s capacity to provide adequate care in that context to serve the best interests of the child. Clinical assessments for courts play a critical role in unearthing the specific
needs of an individual child. Thus, the child’s best interests are always dependent on each individual circumstance.

One main task in court clinicians’ assessments is to translate or ground the child’s needs into the child’s best interests ideas and language in the specific psycholegal framework. This allows for greater consistency in the use of psychosocial evidence in the decision-making process.

Clinicians’ evaluations of the child’s best interests are often requested in situations where it is not clear whether removing the child from abusive and neglectful environments is more harmful than exposing the child to inadequate parenting. Brooks (1999) argued that the most important goal in the best interests of the child is permanency. The goal of permanency has also been articulated in US federal law, in the Adoption and Safe Families Act (1997). Permanency refers to ensuring a child a safe, secure, stable and continuous home in which to grow up. The challenge in decision making and planning for permanency is accurately distinguishing between those parents able to achieve improved parenting and those who are incapable of changing to meet their child’s ongoing needs (Brydon, 2004).

In summary, while the CYFA asserts that the best interests of the child must always be paramount and includes a number of principles to guide decision makers, it does not identify the various aspects of families, the protection system and the individual decision-makers that contribute to the child’s interests. The best interests principle seeks to promote individual decision making in identifying important aspects of families that can be used to respond to the needs of each child. It follows that the task of court clinicians is to provide evidence for the judicial officers to make the decisions that are in the best interests of the child.
As proposed in Chapter 2, the principle of good enough parenting is often invoked in court-ordered assessments where the best interests of the child is the overall decision principle in court-authorised assessments (e.g., Azar et al., 1998; Budd et al., 2001). The fundamental issue complicating the task for decision-makers is, however, the lack of universally accepted standards for court clinic assessments or for court decisions.

**Guidelines for Child Protection Assessments**

There is no one standardized protocol that is always followed in child protection practice. The widely used APA (1999) guidelines for child protection assessments, however, provide general directions for assessments of child protection and parenting capacity. These guidelines and other known assessment schemes cover the assessment procedures, areas to be addressed, and guidance about the assessment process. While these guidelines address the general principles of what is required for assessments of how the child’s needs are best met, they do not address specific areas that need assessment in court child protection assessments in order to fulfil that criterion.

Other clinical guidelines have addressed the specific areas that clinicians commonly cover in child protection assessments, including information about: (1) the parent; (2) the child; and (3) the context in which the parent-child interactions occur (Budd & Hodsworth, 1996; Reder et al., 2003). With this mix of psychological information on parents and children, the clinician has to take a perspective on the critical information surrounding protection-related issues involved in individual families, that is, he or she must identify the issues by defining the problem in decision-making terminology (Guy, 2000; Hill, Glaser, & Harden, 1995).

In line with the APA Guidelines (1999), Brown (1999) proposed a set of procedures for clinical assessments in a comprehensive protocol set up for the
Children’s Court Clinic of Victoria. In this protocol, particularly important aspects about the parents are their history, mental health, personality, cognitive functioning and parenting skills and responsibilities. The child factors include any evidence of significant harm, but also developmental stage, temperament, mental health issues and other individual needs that might add to the parenting load. The contextual factors that are relevant to protective concerns commonly involve families’ social stresses and support networks. Specific questions about family functioning can include assessments of domestic violence, or conflict that may place the child at risk of harm (Brown, 1999).

This local protocol is in general agreement with the US protocols (Budd & Holdsworth, 1996; Hynan, 2003; Reder et al., 2003)

Budd et al. (2001) suggested that the overall emphasis of court child protection assessments is placed at the interface between (1) a child’s developmental needs and the parents’ care-giving skills; and (2) the parents’ competence to care for their own needs and for the child’s needs. This account is consistent with other clinical guidelines used in court child protection evaluations (Hynan, 2003; Reder et al, 2003), which include the general markers of good enough parenting (Azar et al., 1998; Budd & Holdsworth, 1996), as described in Chapter 2.

Hynan (2003) proposed a detailed account for court parenting evaluations including observations of the parent’s day to day ability to: (1) be consistent and reliable with a child; (2) modulate and regulate his or her emotions; (3) be emotionally available to a child; (4) recognise and remain attuned to the emotional status and needs of a child; (5) provide adequate cognitive stimulation to a child; (6) provide adequate and appropriate levels of advocacy for a child; and (7) provide adequate and appropriate care and protection for a child.

Given that parenting assessments in child protection matters are about overall
functional capacities, Azar and colleagues’ (1998) approach adds the significance of different challenges parents face that could impact upon their capacity to parent. These can include the child’s attachment behaviour towards his or her parents (Goldsmith, Oppenheim, & Wanlass, 2001) as well as manifestations of any behavioural problems in the child and how parents respond to the child (Azar et al., 1998; Benjet & Azar, 2003). The child’s attachment or behavioural problems, however, may not necessarily reflect deficits in parenting (Hynan, 2003).

**Functional-Contextual Model of Court Clinical Assessments**

Azar and others (Azar, & Benjet, 1994; Azar et al., 1998; Benjet et al., 2003) proposed a functional-contextual model of court child protection parenting assessments for families where parents suffer from the adverse impact of domestic violence, mental illness or substance abuse. This functional-contextual model is based on assessments of minimal or good enough parenting standards in court ordered assessments. Azar and colleagues argue that psychological assessments in court protection matters should focus on the functional aspects of parenting competence as well as the multiple factors that contribute to protective concerns. The model addresses different aspects of families that may be impacted by parents’ personal problems, the child, the parent and their mutual interaction, and has been used widely in court ordered child protection assessments (Azar et al., 1998; Benjet et al., 2003; Melton et al., 2007).

**Assessing Specific Parental Problems Psychologically**

While parents’ domestic violence, substance abuse and mental health are frequently linked to families that come to child protection courts, none of them automatically translate into failed, or bad enough, parenting practices (Scott & Swain, 2002). There are, however, some aspects that require special consideration in functional assessments of families where parents experience the particular problems of interest in
this research. The functional-contextual model provides some guidance for assessing parenting adequacy in relation to the specific problems of the parents.

**Domestic violence.** In assessments of domestic violence the clinician’s job is to assess whether the violence in the family environment has lead to significant harm to a child as defined in the legislation (Melton et al., 2007). Reder et al. (2003) outline specific aspects of the parent and families in assessments where domestic violence is a concern. Decisions should be based on the overall quality of parenting, the severity of the violence and all other potentially associated forms of abuse, such as sexual abuse and neglect that often co-occur with domestic violence. Assessments of domestic violence can be challenging because in many instances the clinicians deal with allegations of violent behaviour with insufficient evidence.

Kuehnle, Coulter and Firestone (2000), following the functional-contextual approach, proposed a 4-factor model for examinations of child protection matters where domestic violence has occurred. The four factors that contribute to interpretations of violence are: (1) the parent; (2) the environment; (3) the child; and (4) relationships between the parent and the child. The parent-child relationship, in particular, highlights aspects such as parental commitment, attachment and communication styles and any traumatic losses of caretakers – areas that are commonly at risk when domestic violence occurs in families with children.

**Substance Abuse.** Child protection decisions are often based solely on decisions of substance abuse (Olsen, Allen, & Azzi-Lessing, 1996). According to a functional-contextual approach, however, evidence of parents’ substance abuse is not enough to determine whether the parents have adequate parenting skills (Benjet et al., 2003). It is therefore important to address the areas of child and family functioning that are commonly known to be adversely affected by substance abuse. For example, some
children may be left feeling anxious due to the parents’ unpredictable behaviour from drug use or alcohol related absences whereas other children may not be impacted to the same level (Benjet & Azar, 2003; Fals-Stewart, Kelley, Fincham, Golden, & Logsdon, 2004).

**Mental health.** While some parents with mental health problems maltreat their children, the actual risk of harm is primarily the function of the parents’ behaviour and not their illness (Reder et al., 2003). In functional child protection assessments, the main question relates to the impact of parents’ mental disorders on child development (Melton et al., 2007).

A diagnosis of mental illness does not automatically lead to inadequate parenting practices or significant harm to a child (Melton et al., 2007). Mental health assessments may be severed in cases where parents fail to co-operate and lead to inadequate scrutiny of the parents’ functional parenting capacity, leading to decision-making based on incomplete evidence (Reder et al., 2003).

Overall, a wide range of child, parent and family aspects are commonly addressed in assessments of child protection concerns to assist court decision-making. Most family assessments in child protection matters, however, are about parents’ capacity to provide children with a safe environment in the family context (Azar & Benjet, 1994; Azar et al., 1998). Assessment reports to courts are required to include information about individual child, parent, and family functioning, evaluations of parent-child interactions, and a child’s attachment to the caregiver.

The main focus in parenting evaluations in court protection matters seems to be matching a child’s needs to the specific contextual and functional abilities of parents, or a lack thereof. These guidelines provide a useful framework about the important areas to cover in court child protection assessments. They do not, however, address what the
clinicians actually do and the tasks involved in clinicians’ assessments that lead to specific recommendations to court.

**Clinicians’ Use of Information in Child Protection Assessments**

While guidelines for practice are relatively advanced in describing what clinicians should include when conducting psychological assessments, there is a call for more systematic investigations about the processes that take place in these assessments (Elbogen, Mergado, Scalora, & Tomkins, 2002). No one account systematically describes the ways in which clinicians use the assessment information about parent problems in particular, when making recommendations to the court in child protection matters. The descriptions of clinical assessments and decision-making in medical, psychological and legal contexts vary between and within broad frameworks. The ways clinicians define the major issues, weigh and interpret the information and translate the issues and evidence into recommendations is dependent on the decision processes involved and the heuristics used.

A traditional focus in research on psychological assessment has been on the assessment procedures in the form of psychological testing and the psychometrics of formal assessment tools (e.g., Cichetti, 1994; Delis, Freeland, Kramer, & Kaplan, 1988; Floyd, 1995; Watkins, Campbell, Nieberding, & Hallmark, 1995). Very little is known about how these tests and various guidelines are applied in practice. Particularly important in child protection matters is how protective concerns are interpreted and translated into final conclusions through psychological and legal insights. These conclusions and subsequent recommendations to court are impacted upon by the interplay between the particular context, individual characteristics and types of presenting problems (Hogarth, 1987). Bringing this material together involves identifying the issues in relation to psychological and legal criteria.
A generally used practice model, as proposed by Barnum (1993) and Budd with others (Budd, 2005; Budd, Boindexter, et al., 2001), for clinical court assessments follows from the rational decision-making model by identifying three important steps in the decision process: (1) establishing or identifying the clinical problem with the help of background records or other available information; (2) collecting relevant information involving clinical interviews, psychological assessment tools, observations of the child-parents interaction and other collateral sources of information; and (3) integrating relevant findings and recommendations into the provision of outcomes. Specific to the final phase, where the assessment process differs from general clinical practice, are the expert witnesses’ interactions with the courts.

Identifying the issues. Decision processes, in general, are impacted by the ways the decision-maker identifies the problem. Rational decision-making is described by Guy (1990), and is applied to clinical decisions (Hill et al., 1995). It starts with defining the problem by isolating the key factors that present in the given circumstances. Problem definition, then, informs possible solutions to the problem. The greater the complexity in the initial problem set, the greater the number of possible solutions. Once the different alternatives are identified, the decision-maker may rank the alternatives hierarchically by combining similar characteristics into categories, reducing information into chunks of characteristics to guide the final conclusion.

Because the data in this research were existing reports, they could not yield information on the process of decision-making followed by clinicians. The report is the product of their reasoning. However, in order to present their recommendations as plausible and grounded in evidence and expert judgment, the clinician usually specifies what s/he is focusing on. This is the identification of the assessment issues for the case. Therefore, in this present research, the clinicians’ identification of assessment issues is
treated as the psychological focus that is then linked to their summations and recommendations.

One downfall in the rational decision-making model is that it assumes that the decision-maker considers all possible factors that may influence outcomes. Considering all possibilities and alternatives, however, is beyond the capacity of the human mind. All humans, including clinicians, make use of heuristics.

**Heuristics in clinical assessment.** The process of clinical assessment is largely influenced by clinicians’ experience along with the limitations of human information processing capacity (Benjet et al., 2003; Hill et al., 1995). Many attempts have been made to capture the essential cognitive processes involved in clinical assessment (Garb, 1998). This research tradition has been able to introduce specific cognitive shortcuts, called heuristics (Tversky & Kahnemann, 1974), that assist in narrowing down information and focusing on certain case characteristics that are relevant to the presenting problems (Nezu & Nezu, 1995). The use of heuristics allows the clinicians to form rules, schemes and prototypes that are applied in clinical contexts (Westen, 2005).

Instead of processing a large quantity of information, the decision-maker can concentrate on patterns of information in assessments. The ways clinicians cognitively frame their assessments ultimately determines what risk factors they use and which case characteristics are considered in formulations, final conclusions and recommendations (Grisso, 1998; Heilburn, 1997).

While heuristics may render the clinical assessments vulnerable to uncertainty and human error (Garb, 2005; Turk et al., 1988), when combined with context-specific understanding and experience the use of heuristics can be effective for expert clinicians by allowing them to integrate and interpret dynamic case factors in more complex ways (Ivey & Scheel, 1999). Domestic violence, for example, routinely raises concerns about...
the safety of all family members. There are, however, many ways violent behaviour affects child well-being that would impact upon clinicians’ interpretations. For example, the family context and the individuals within that context largely affect the level of harm arising from violence. What adds to the complexity of understanding domestic violence is that clinicians often deal with indirect evidence, allegations and contradictory information from multiple sources (Brown, 1999).

**Assessment issues.** One way clinicians use heuristics to reduce information processing load is to set up initial hypotheses prior to carrying out the assessment (Elstein, & Schwarz, 2002; Jones, 1988; Tanner, Padrick, Westfall, & Putzier, 1987). As described by Guy (1990), decision-processes are set up by the initial definition of the problem. Setting the initial context for the assessment, in general, allows the clinician to organise information into categories, groups, or clusters based on patterns of case characteristics (Dowie & Elstein, 1988; Jones, 1988; Kim & Ahn, 2002).

In child protection matters, the focus of assessment is associated with the problems that pose a threat to child safety or well-being. This involves specifying what the assessment is about: the issues that impact on decisions about protection and placement. Over and above other guiding principles, assessment issues guiding the assessment need to address the child’s best interests in providing evidence to courts (APA, 1999). This evidence usually involves questions about the child’s placement, relationship with the biological family or specific issues in the family that need to be managed with support services (Brown, 1999).

The assessment issues, then, seem to impact on the types of risk factors clinicians emphasise in their final summations and conclusions (Elbogen et al., 2002). The final conclusions are affected by the salience of the available information within the situational context (Guy, 1990). Zabow and Cohen (1993), for example, suggested that
the history of violence and substance abuse and delusional manifestations of mental illness weighed heavily in clinicians’ interpretations of patients’ dangerousness. Some empirical evidence exists on the types of risk factors or cues clinicians use in risk assessment of matters often invoked in court cases. In relation to violence, for example, clinicians focus their decision-making on previous violence, alcohol abuse and poor anger management (Menzies & Webster, 1995). In relation to substance abuse, clinicians are likely to focus on parents’ willingness to attend regular screening tests. In relation to mental health issues, clinicians typically use their own psychological interviews to establish judgments about mental health status.

**Studies of assessment issues related to parenting problems.** Heuristics allow the clinicians to focus on relevant case information but may also result in ignoring or misinterpreting relevant information, particularly under time pressure and dealing with a wealth of complex information. Studies of risk assessments, also common in child protection evaluations, delineate the types of case factors that clinicians emphasise in making recommendations to the court. These factors are commonly related to the salience and seriousness of each factor and potentially causal relationships with other salient case characteristics.

One study of mentally ill patients (Segal, Watson, Goldfinger, & Averbuck, 1988) revealed that clinicians considered the severity of mental illness as predictive of dangerousness. Hostility, history of violence and the presence of serious thought disorder have also been associated with the issues and level of risk perceived by clinicians (Lidz, Mulvey, Apperson, Evandzuck, & Shea, 1992). Another study by Lidz and colleagues (Lidz, Mulvey, & Gardner, 1993) showed that clinicians tend to underestimate female violence but are more realistic in assessing the risk of male violence. It may be that gender plays a role in the ways clinicians use and interpret case
Other research shows that clinicians rely on salient cues such as extreme symptoms of mental illness, even when these cues were not relevant to the presenting problems including risk of violence (Quinsey, Lalumiere, Rice, & Harris, 1995). Not only salience, but also information that is associated with negative outcomes seems to be weighed more in comparison to information related to positive outcomes or resilience. For example, parents’ substance abuse may be emphasised over and above other case characteristics in child protection matters, given its detrimental impact on both abusive behaviours and mental health problems. A curious pattern in violence risk assessments found by Elbogen et al. (2002), however, was that clinicians tend to over-emphasise the importance of certain violations (murder) and under-emphasise others (sexual abuse). This evidence suggests that salience is related to the level or seriousness of the negative outcomes (murder vs. sexual abuse) as an additional factor.

Earlier studies on clinical assessments have shown that clinicians emphasise case features that are similar to prototypes, frequently occurring patterns of incidents or known theories (Blashfield, Sprock, Pinkston, & Hodgin, 1985; Cantor, French, Smith, Mezzich, 1980; Evans, Handley, Over, & Perham, 2002; Garb 1996; Genero & Cantor, 1987). One line of research suggests that clinicians use an internal weighing scheme based on their previous experience (Dowie & Elstein; 1988; Jones, 1988). Welsh and Lyons (2001) found that nurses’ mental health assessments were guided by their subjective experience, informed by formal knowledge about the presenting problems. In particular, the use of subjective criteria in assessments is more heavily endorsed in the absence of clearly defined and pragmatic guidelines (Budd et al., 2001; Jones, 1988). It may be that the level of concern clinicians place on salient, negative case characteristics is also based on clinicians’ subjective experience of the individual problems or patterns
of problems. Similarly, Kim and Ahn (2002) found that any symptoms or conditions that clinicians perceived in causal relation with other symptoms were given more weight than other symptoms.

In summary, the factors that influence the focus of clinic assessments and recommendations include the identification of specific assessment issues in framing the simultaneous consideration of several alternatives and explanations and the weighing of certain salient factors in specific family environments (Arkes, 1991; Falvey, 2001; Gambrill, 1990; Garb, 1998; Turk & Salovey, 1988). These related factors must be summarised into a set of recommendations about placement and orders.

In child protection matters both the legal and clinical criteria inform court clinicians about the best interests of the child in making recommendations to the court. These criteria are laid out in both legislative principles and the clinical guidelines for child protection assessments. Based on these analyses, clinical decision-making seems to be a process involving several stages. Not only information processing strategies, but also the nature of specific tasks, define the focus of assessments.

While clinical guidelines and legislative decision-making principles provide the framework for child protection assessments, the ways clinicians select and emphasise case details also guide the assessment task. Taken together, this review suggests that clinicians tend to pay attention to causally related, negative and salient case characteristics relevant to known diagnostic (or clinician’s own) criteria, even if irrelevant to the presenting problems. It seems reasonable to expect that this is the case in court child protection assessments where clinicians are requested to provide evidence about a risk of significant harm to the child. Negative factors related to parents indeed involve the most prevalent issues contributing to protective concerns: domestic violence, substance abuse and mental health problems. These factors are likely to be
linked to clinicians’ interpretations of the best interests principle. As discussed, the best interests of the child are particularly crucial in decisions about children’s placement. In these situations the clinic and court are required to make an informed judgment about whether parents can provide good enough care for their children or not.

Factors Associated with Recommendations and Decisions about Children’s Placements

Nearly all clinic assessments in child protection matters conclude with a set of recommendations about what is needed to provide a safe environment that serves the child’s best interests (APA, 1999). Fewer assessments add recommendations about the appropriate intrusiveness that is reflected in court orders. A custody order, for example, gives the decision-making powers to the Secretary of the Department of Human Services. A supervision order, while allowing protection workers to intrude into the life of the family, does not affect the parents’ responsibility in the same way. Therefore, while some placement recommendations are associated with specific kinds of orders, the clinician does not always address the magistrate’s orders specifically. As far as can be ascertained, there is no body of research about clinicians’ recommendations for court orders. This section, therefore, focuses on placement recommendations.

Some guidelines discourage clinicians from making explicit recommendations and instead suggest that they should simply provide the descriptive material about the risks and protective factors that can inform the court (Budd et al., 2002). However, the clinician making an expert recommendation knows that the judge or magistrate will use his or her recommendations along with other evidence to make a court decision.

A handful of studies have independently examined how clinicians arrive at recommendations of placement (Rossi et al., 1999; Schuerman, Rossi, & Budde, 1999) and how recommendations are followed up in court (Butler et al., 1995; Jamieson et al.,
While Chapter 2 established that particularly parental domestic violence, substance abuse and mental health problems are overrepresented for children placed in out of home care, no known studies have systematically examined how these problems are associated with the co-ordination of clinic and court decisions about placements. It was one of the aims of this research to address this co-ordination issue.

Statutory removal of a child from their biological family is only warranted in situations where protective concerns have resulted in significant harm to the child and interventions have not improved the circumstances (Reder et al., 2003). The disruptive nature of removing children from their parents prompts both due process protections and higher standards of proof than may be required in other phases of child protection proceedings. These also need to be adequately justified in parenting assessments (Condie & Condie, 2007).

Kinship care and out of home care are placements where children are placed by court orders in matters where the court deems the parents’ care as inadequate in order to not place their child at risk of significant harm. More evidence exists on factors associated with the decision to place a child in out of home care.

**Out of home care.** Some evidence in the field of social work has come from investigations into case characteristics that are related to placement decisions. McConnell et al. (2006), for example, showed that social workers’ perceptions about parents’ compliance was a major predictor of recommendations to place children in out of home placements. Parental refusal to engage with support services has also been linked to re-entry into the protection system in the first year after returning the child to parents’ care (Festinger, 1996). Rossi and others (1999) showed that when making custody judgments, workers and clinical experts consistently place the greatest weight on prior complaint records. Families with prior complaint records were much more
likely to have their children taken into custody.

Unfortunately, parents in greatest need also tend to use fewer services. Early research identified a poor motivation factor among parents whose children are removed and not returned to their care (Fanshel & Shinn, 1978; Magura, Moses, & Jones, 1987). This included parents’ resistance towards interventions and negative reactions. More recently, Leschied and colleagues (2003) found that less intrusive decisions about the protection of the child positively related to the caregiver's motivation to cooperate with interventions, the family's ability to cope with stress, the caregiver's physical and mental capacity to care for the child and the child's mental and behavioral development.

Lindsey (1992) investigated the predictors of out of home placement as reasons for seeking services. Children in families seeking help for substance dependency, child behavior problems or other mental health problems were most likely to be removed from their home. Zuravin and DePanfilis (1997) found that children in families with recurring maltreatment and in which the mother had difficulties with violence, substances, or mental health were more likely to experience foster care placement. Similarly, Horwitz, Hurlburt, Cohen and Zhang (2011) found that the strongest predictors of out of home placements were low income and multiple parent problems (i.e., intimate partner violence, mental health issues, history of maltreatment).

Removing children from their families was not related to whether the families were engaged with services, but rather to multiple risks in the family environment.

Given that instability can have significant adverse affects on children, one important factor to consider in placement decisions is the stability and long-term prospects of the child’s living arrangements (Delfabbro, Barber, 2003; Shaw, 2006). For example, Rubin and others (2007) found that placement instability increased a child's
risk for behavioural problems that could not be explained by the initial problems that a child had at the time of the placement decisions.

**Kinship Care.** When parents are unable to provide adequate care for children in the immediate family, the use of relatives as foster parents enables children to remain within their own extended families, traditions and cultures, as well as minimizing the trauma of placement with unfamiliar people and surroundings (Berrick, Barth, & Needell, 1994). While there are not many investigations into the parental factors associated with kinship placements, some evidence shows that older children, children without disabilities, ethnic minorities and children with parental substance abuse are more likely to be placed in kinship care than in other out of home placements (Beeman, Kim, & Bullerdick, 2000; Iglehart, 1994).

**Family reunification.** The legislation at the Children’s Court of Victoria (CYFA, 2005) asserts that in matters where a child is removed from their biological family, a reunification plan is to be put in place where appropriate. The question of reunification is important in child protection decisions. Empirical evidence, however, shows some inconsistency about how family reunifications are associated with child and family characteristics. Previous research, for example, shows that very young children have a lower rate of reunification than older children (Courtney, 1994; Goerge, 1990; Westat and Chapin Hall Center for Children, 2001), while other evidence shows no significant age affect (McMurtry & Lie, 1992; Wells & Guo, 1999).

Further, some studies suggest that children removed for neglect are less likely to reunify than other children (Courtney, 1994; Davis, Landsverk, & Newton, 1997). Results from other studies, however, show that children removed for neglect have a higher rate of reunification than children removed for physical abuse (Goerge, 1990; Wells & Guo, 1999).
In addition, children in kinship care reunify at a slower rate than children in other out of home care placements but are also less likely to re-enter the child protection system than children in other placements (Courtney, 1994; Davis, Landverk, & Newton, 1997; Goerge, 1990; Westat and Chapin Hall Centre for Children, 2001). These results suggest that kinship placements offer higher placement stability than other out of home placements.

Finally, some claim that children from two-parent households reunify faster than other family structures (e.g., Courtney; 1994; Wells & Guo, 1999), while Davis and colleagues (Davis et al., 1997) suggest that children removed from single-parent households have shorter stays in foster placements than children removed from two-parent families.

While some attempts have been made to characterise what is involved in the court-authorised clinical assessments and recommendations made for courts in child protection matters (e.g., Budd et al., 2001; Butler, Atkinson, Magnatta, & Hood, 1995), no existing studies have systematically analysed how clinicians use and interpret parents’ problems in clinicians’ assessments in a psycholegal framework. The final section of this chapter provides a rationale for the method of analyses for the current research. The current research uses content analysis to describe the important factors involved in the assessment process and reporting back to the court.

**Analysing Clinical Assessments**

Archival records provide access to public records and materials that are available as sources of data (Hill, 1993). Archival content analyses have been previously employed in court contexts involving children to obtain information, for example, about child sexual abuse assessments (Pellegrin & Wagner, 1990), court clinic recommendations of placements, interventions and judicial dispositions (Butler et al.,
Archival content analysis is a useful research tool in being more holistic than clinical interpretations of case features when certain criteria are not made explicit prior to analyses (Smith, 2000). Archival content analysis is particularly useful in describing unknown phenomena or exploratory analyses not structured in advance. By using content analysis, the assessment reports can be reduced to more manageable units of information by coding frequently occurring concepts for both numerical and textual analyses.

Content analysis of archival data can bring a different perspective to material that has been produced in an original context of inquiry without the distraction of researcher involvement and bias. Thus, analyses of archived material can provide new ways of understanding phenomena that may otherwise be disregarded in quantitative, more objective methods of analysis. Content analysis is “a research method that uses a set of procedures to make valid inferences from text” (Weber, 1990, p. 9). Spoken and written reports are an obvious source of information about how an individual thinks about matters, and many such reports can be found in data archives (Lee & Peterson, 1997).

What makes content analysis more than just a clinical description of reports is the explicit specification of the rules used to make inferences. Content analysis requires that the researcher obtain suitable material, develop a coding protocol and ensure the reliability and validity of coding schemes (Lee & Peterson, 1997). In this sense, content
analysis is no different in principle from other research methods, even when the initial data are archived (i.e., gathered for another purpose and often by another researcher).

Content analysis can provide information about concepts in the data that may otherwise not be accessible by other methods (Smith, 2000). Content analysis involves systematic reading of texts that is specifically useful in making inferences about phenomena that cannot be observed directly (Krippendorf, 2004). The emphasis and inferences of the report writer can be followed systematically. The current research uses this approach to analyse clinic reports. It is used to investigate patterns and the interrelationships that illustrate the ways in which clinicians select and emphasise case information in making reports back to the court.

This method is also appropriate for the current analyses due to the sensitive nature of the data and issues addressed in the assessments (Smith, 2000). As argued above, the clinicians’ reports to the court are actual recommendations that are part of the child protection system. Child protection is a sensitive issue for all professionals and for the families involved. For example, the Victorian government has been reviewing the state’s statutory child protection system several times in the last 10 years and the procedures in place that ensure the child’s best interests are met at each step of the involvement from child protection authorities, a process that is still ongoing (Bromfield & Higgins, 2005).

In initial investigations of the role of the clinic, it was suitable to begin with existing material. Further, content analysis has been used as initial data in other related areas (e.g., Bauer & Barnett, 2001; Budd et al., 2001; Butler et al., 1995). The wealth of material in written reports provides comprehensive information about the assessment procedures and the clinicians’ inferences that ultimately lead to court final decisions. The form of content analysis for the current research aims to systematically identify the
specified case features that frequently occur in the clinicians’ reports to the court. These involved the problems of parents and children, families’ court history, clinicians’ interpretations of the case characteristics and subsequent recommendations to the court. The ultimate aim of these analyses is to illustrate the ways that clinicians come to their recommendations given the problems of the parents.

**Current Research**

The current research involved two studies. Study 1 involved content analyses of clinicians’ reports with a special focus on the problems of the parents and the significance of those problems for clinicians’ attention to family details, assessment issues and placement recommendations. Study 2 focused on the outcomes of clinicians’ recommendations in relation to decisions made by the Children’s Court of Victoria, and in particular, a finer analysis of clinicians’ attention to the parent problems established as significant in Study 1. Study 2 more thoroughly explored the clinicians’ use of parent problems, giving each problem (i.e., domestic violence, substance abuse, mental health) a salience score according to the level of seriousness and concern for the problem, as described in this chapter, for the father and mother of 138 families. The salience of the parent problems is then related to outcomes for the clinic and for the court.

**RESEARCH QUESTIONS**

**Study 1**

*Research Question 1* for Study 1 involved identifying the prevalence and patterns of three common forms of parental problem in the clinicians’ reports to the court. As discussed in Chapter 2, domestic violence, substance abuse and mental health problems have been shown to occur and co-occur frequently in child protection matters (Bishop et al., 2000; Carter & Myers, 2007; Gracia, 1995; Whipple & Webster-Stratton,
Azar and others (Azar et al., 1998) proposed that assessment of these common problems would constitute a step towards identifying the functional dimensions of parenting capacities and behaviours, particularly in families where there are protective concerns (Benjet et al., 2003, Melton et al., 2007). Clinicians and other professionals working in child protection typically treat these common problems as indicators of family problems leading to inadequate parenting (Benjet et al., 2003).

Since these common problems have not previously been identified as a set of potentially co-occurring issues for both biological parents, the first aims were: (1) to identify the frequency with which clinicians mentioned domestic violence, substance abuse and mental health issues in relation to the biological fathers and mothers of children referred by the Children’s Court of Victoria; and (2) to analyse the patterns in which they occurred or co-occurred in the reports.

**Research Question 2** for Study 1 focused on whether the patterns in parent problems were systematically associated with other case characteristics, including assessment issues, such as the focus of clinicians’ assessments identified as important in guiding their assessment issues and summations and the child-related issues identified in Chapter 2 (e.g., emotional and behavioural problems; Christoferssen & DePanfilis, 2009; Martinez-Torteya et al., 2009; Moehler et al., 2006), as well as placement decisions (Baer et al., 2003; Booth et al., 2005; Miller & Finnerty, 1996) and the ways in which clinicians interpret and use the information about children and parents in making recommendations about placements (Horwitz, et al., 2011; Magura et al., 1987; Zuravin & DePanfilis (1997).

Specifically, then, the second set of aims for Study 1 addressed how the patterns of parent problems were associated with: (1) child-related issues; (2) assessment issues
identified by clinicians; (3) parents’ involvement in the assessments; and (4) clinicians’ recommendations about placements.

**Study 2**

Study 2 was designed to: (1) specify the level of attention (salience) the clinicians’ gave to the three types of problems for the father and the mother (domestic violence, substance abuse and mental health); (2) examine the relationships between clinicians’ recommendations and court decisions (court protection orders, children’s placements); and (3) relate clinicians’ emphases on parent problems (their salience) to these outcome decisions.

This chapter proposed that the identification of assessment issues and the salience of negative factors contributed to clinicians’ decision-making processes and subsequently to the recommendations they made available to the court. In particular, Chapter 2 proposed that the level of salience surrounding parent problems would be associated with the clinic recommendations and court decisions about child protection orders and children’s placements. Given that any change in the current situation is likely to cause distress to the family unit, it was particularly important to explore the change in relation to the current situation recommended by the clinicians and ordered by the court.

*Research Question 3* for Study 2 involved specifying the level of attention clinicians gave to the problems mentioned concerning parents in the same families. The salience measure was generated to identify the level of clinicians’ concern with the current state of each problem. The specific aims were to: (1) identify any systematic differences in the salience scores between three types of parent problems for fathers and mothers; (2) examine the relationship between clinic recommendations and court final decisions; and (3) analyse whether assessment issues or the salience of parent problems,
as identified by the clinicians, were associated with the clinic and court opinions about child protection orders and children’s placements.

Taken together, these three research questions paint a picture of how the problems of biological parents relate to clinicians’ recommendations and court final decisions about families where child well-being is at risk. In particular, it illustrates the practical aspects of how parent problems are considered in assessments about the best interests of the child and how clinicians’ recommendations are followed up at the court.

**Summary**

Clinical assessments in child protection matters deviate from those in general psychological practice. This chapter proposed that major factors shaping clinical assessments for court purposes include the integration of the legislative principle of the child’s best interests, following clinical guidelines for child protection practice and the use of specific case information that clinicians consider important for the protection of the child.

First, families that come to the attention of the protection system have already been identified as showing major problems and so the general guidelines for families within the normal range do not apply. Second, the authority of courts adds another aspect to clinical assessments. Clinicians use their expert clinical training in processing information about families but are also required to communicate the information in a way that is practical in the legal framework. The recommendations for the court, then, stem from an interactions between the expert psychological knowledge of the families, the law and available resources.

Clinicians’ weighing and interpreting of case information is context-specific and as much determined by presenting problems as individual case characteristics. Crucial factors in making recommendations to the court seem to be causal and central
factors that form a consistent ‘story line’. Parental compliance with court orders, for example, is perceived as a crucial factor in determining the risk of future harm. Also, negative case characteristics, such as parents’ mental health and a high risk of domestic violence in the family, seem to be emphasised more than those linked to resilience and well-being.

While identifying the standards clinicians use in their assessments is difficult, the focus of inquiry in court ordered clinical assessments should be on the different factors that impact upon the child’s safety and protective concerns. This approach will inform how the courts use expert psychological evidence in final decisions concerning the best interests of the child.
Chapter 4  
METHODOLOGY FOR STUDY 1  
ANALYSES OF CLINICIANS’ REPORTS TO THE CHILDREN’S COURT OF VICTORIA

This chapter describes the methodology for the analyses in Study 1 of psychosocial assessments carried out at the Children’s Court Clinic of Victoria. The chapter begins by describing the reports of 250 children and their families referred to the clinic by the court. The unit of analyses for Study 1 were the full-length clinic psychological reports. The procedure for the study is introduced, which involved accessing and downloading the reports from the clinic Emu database, and extracting and coding parent, child and court information from the reports. Then, the focus moves on to a description of analyses of the patterns in parent problems for biological fathers and mothers of the 250 children. The analyses focused specifically on these patterns and how they were related to other parent and child information, assessment issues, current court decisions and clinicians’ recommendations about placements in relation to the 250 children assessed at the clinic.

The Reports

The analyses targeted a sample of 138 psychological reports that were produced by the clinicians of the Children’s Court Clinic of Victoria on the request of the Children’s Court of Victoria. Selection criteria for the court clinic reports were that the psychological assessments were requested by the court between July 2006 and June 2007, that the matter was referred from the family division of the children’s court, and that the reports were available in the clinic’s electronic Emu database.

The 138 reports addressed referrals for families involving 250 children. The sample comprised 22% of all the 638 child protection matters that were referred to the
clinic in one year (2006-07; Children’s Court of Victoria, 2007). All assessments were made in response to court referrals.

The sample of 138 reports was the first set entered into the court clinic electronic data management system, Emu. The clinic staff made these reports available for downloading and analysis as they entered them into the database. Fifty-two percent of the 250 children were boys with a mean age of 7.51 (SD = 4.50, range = 0.1 to 15.8 years), and 42% were girls with a mean age of 7.26 (SD = 4.37, range = 0.3 to 16.5 years). The children’s ages were evenly distributed across boys and girls. In the sample of 138 reports there was a mean of 2.42 (SD = 1.20, range = 1 to 5) children included in each report.

There were 155 biological fathers and 139 biological mothers mentioned in the 138 reports. The data for the ages and other demographic information for the parents were incomplete, and some data were not available at the clinic (e.g., some parents were reluctant to disclose their age to the clinic personnel). Parents’ living arrangements were not always clear in the reports. For example, fathers may have been under court orders not to live with the families, often because of violence issues. Information about living arrangements was only available for the research if it was reported by the clinicians in their reports. This information was available for only 150 out of 250 children. Of these children, as mentioned in the assessments, the biological parents of 99 children were separated. The living arrangements for the other 51 children may or may have not been stable. Of the 99 children whose parents were reportedly separated, 23 were living with their mothers and only 6 with their fathers. The remaining 70 were in out of home and kinship placements. These statistics must be treated with caution as there was no single source of information for clinicians.
The full assessment reports usually included information on: (1) the background information from the court and department of human services; (2) protection history with professional involvement in the family members’ lives; (3) detailing of persons who were assessed and interviewed for the report; (4) choice of methods of assessment; (5) description of the assessment and/or interview of each person; (6) clinical formulation of the assessment and presenting problems; and (7) dispositional summaries and recommendations to the court. Not every clinician, however, followed the same organisation for each report. At the least, each report covered the clinician’s assessment issues, formulations and recommendations. For example, most (246) children had a recommendation for placements and all (250) had a recommendation for court protection orders.

If basic information was not recorded in the report by the clinician, additional demographic and court information were obtained where available from the clinic data management system, Emu (e.g., child’s date of birth, gender).

Clinicians

Twenty-five clinicians conducted the 138 assessments and wrote the reports to the children’s court. These clinicians were psychiatrists, clinical psychologists or clinical neuropsychologists, child and family psychologists, or forensic psychologists. They were specialist or generalist clinicians with expertise in court related clinical assessments at the children’s court. It was a condition of this project that the identity of individual clinicians was not known. Accordingly, clinicians’ reports were de-identified at the time of downloading. Consequently, the individual clinician does not constitute a variable in the analysis.

Clinic Assessments

The clinic undertakes clinical assessments for the children’s court family
division and the criminal division. The family division processes mainly involve protective applications, whereas the criminal division deals with children who have engaged in criminal conduct. For the purposes of the present study only referrals from the family division were included.

**DATA MANAGEMENT**

The data management protocol for Study 1 begins with the procedure for accessing, downloading and de-identifying the reports produced by the court clinic clinicians. Subsequently, a scheme for extracting and coding information from the reports is described. The chapter concludes with the method for analyses in Study 1.

**Accessing and De-identifying Reports**

The year 2006-07 was chosen as the target year because the CYFA 2005, under which the court and the clinic operate, became effective in 2006 and it was preferred that the assessment requests from the court were made under this new legislation. In 2006-2007, 18% \(N=6,962\) of 38,675 child protection reports proceeded to the Children’s Court of Victoria. The court clinic received a referral for 638 cases from the magistrates, that is, 9% of all the protection matters before the court. The 138 reports from the court clinic represented 22% undertaken in the year 2006-07.

The clinic’s Emu electronic system had allocated each child an ID number used for the identification of each report after de-identification. Each report was de-identified by the researcher using the Microsoft Word ‘replace’ command to remove any other identifiable information. An electronic master list of all names and ID numbers was generated and kept at the clinic on a secure hard drive.

Nine procedural steps followed for downloading and de-identifying are shown in Table 3.1. The protocol for accessing clinic records of assessments and recommendations from the clinic’s computerised Emu program were approved by the
As described in Table 3.1, the first step was to open the Word format report together with the Emu system to ensure that the reports were child protection matters, and that the Emu had a record of the report and of individuals involved in the assessment. After de-identifying the report, the report was saved in a different computer location with case and client numbers assigned by Emu. The case number and a child’s name were added to the master list. De-identified electronic copies were saved in clinic and university secured computer drives.

Table 4.1

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Retrieve a Word format report from the clinic computer hard drive</td>
</tr>
<tr>
<td>2</td>
<td>Open the report and EMU data management system</td>
</tr>
<tr>
<td>3</td>
<td>Check that the report is a protection case and that it is also recorded in EMU</td>
</tr>
<tr>
<td>4</td>
<td>De-identify the report by using Word’s ‘replace’ command</td>
</tr>
<tr>
<td>5</td>
<td>Record the client ID and client name in a master list kept at the clinic</td>
</tr>
<tr>
<td>6</td>
<td>Print out the de-identified file and write in the client ID number</td>
</tr>
<tr>
<td>7</td>
<td>The de-identified hard-copies are stored in a locked room in a locked filing cabinet</td>
</tr>
<tr>
<td>8</td>
<td>Code up the file and enter into a coding scheme</td>
</tr>
<tr>
<td>9</td>
<td>An SPSS file is created for each client for demographic and other quantitative information</td>
</tr>
</tbody>
</table>

The de-identified reports were printed and stored in a locked filing cabinet at the university. Selected information was coded from the extracted text and entered into SPSS for analyses.
Extracting and Coding Information from the Reports

The information extracted and coded from the clinic reports involved: (1) the parents; (2) the child; (3) clinicians’ identification of assessment issues; and (4) clinicians’ recommendations to the court about children’s placements.

Parent Information

In each report, the clinicians provided a list of individuals that were present and interviewed on the day of the assessment. Information about parents’ specific problems were mentioned in the clinic reports included domestic violence, substance abuse and mental health pro

Clinicians’ Mentions of Parent Problems

Clinicians’ mentions of parent problems were categorised into 3 groups, (1) domestic violence; (2) substance abuse; and (3) mental health problems in relation to biological fathers and mothers. For each individual child in the clinic reports, the clinicians’ mention of each of the 6 parent problems was coded as ‘mentioned’ if the clinician mentioned it in any section of the report (i.e., background information and other agency and previous reports, interview material, the clinicians’ formulation and recommendations). For example, if the clinician commented that an assessment revealed the diagnosis of a biological mother’s psychosis or clinical depression, for the child, a mental health issue was coded as being mentioned in relation to that mother. The three parent problems in relation to each child were coded according to the Coding Manual (Appendix A), which is summarised in Table 3.2.

This method of coding yielded a set of descriptors of parent problems that recorded any association of a biological father and mother with any of the three parent problems, allowing analyses of the parent problem material in the clinicians’ reports.
This follows a pattern used by other researchers on child protection assessments (Bauer & Barnett, 2001; Budd et al., 2001; Butler et al., 1995).

Table 4.2
Summary of Codifications for Three Types of Parent Problems in Relation to Biological Fathers and Mothers

<table>
<thead>
<tr>
<th>Parent problem</th>
<th>Coding rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Domestic violence</td>
<td>Mentions of domestic violence towards the child or a family member, more than one person’s report, or departmental report for biological parents.</td>
</tr>
<tr>
<td>2 Substance abuse</td>
<td>Mentions of any drug or alcohol abuse incidents, more than one person’s report, or departmental report for biological father or mother.</td>
</tr>
<tr>
<td>3 Mental health problem</td>
<td>Mentions of diagnosis of mental illness or a mention of symptoms consistent with a diagnosis (excluded are mentions of intellectual or cognitive disorders for biological father or mother).</td>
</tr>
</tbody>
</table>

**Inter-rater agreement for the three types of parent problems.** The coding scheme used to code all 3 parent problems separately for biological fathers and mothers of all the 250 children involved assigning either ‘0’ = *not mentioned* or ‘1’ = *mentioned* for domestic violence, substance abuse and mental health, respectively. A second coder independently coded 20 (15%) reports. For the six forms of parent problems, there was a 97% agreement rate between the two coders for 120 codings \( (k = .94, SE = .08, 95\%) \). Disagreements were resolved by discussion.

**Child Information**

Each child’s age and gender were recorded in the clinic report. If the reports omitted these details, they were obtained from the clinic personnel where possible. Clinicians’ mentions of behavioral and emotional problems and a history of neglect and sexual abuse were extracted if there was a specific mention in the report. These mentions were child specific and could include, for example, information on persons other than biological parents, such as perpetrators for sexual abuse.
**Child-Related Issues**

Child-related issues were categorised as clinicians’ mentions of child behavioural problems, emotional problems, exposure to neglect and sexual abuse, respectively. These issues were coded as binary (0=not mentioned, 1=mentioned) categories for each child. The coding rules are shown in Table 3.3.

**Table 4.3**

*Coding Rules for Child Behavioural and Emotional Problems, Neglect and Sexual Abuse.*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coding rule summary (0 = not mentioned; 1 = mentioned)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Child behavioural problems</td>
<td>Mention of diagnosis or symptoms consistent of disruptive behavioural problems or other child behavioural problems as specified in the DSM-IV (APA, 2000).</td>
</tr>
<tr>
<td>2 Child emotional problems</td>
<td>Mention of a diagnosis or symptoms consistent with anxiety, trauma and mood disorder as specified in the DSM-IV.</td>
</tr>
<tr>
<td>3 Neglect</td>
<td>Mentions of physical or emotional neglect by a parent or carer.</td>
</tr>
<tr>
<td>4 Sexual abuse</td>
<td>Mentions of proven or alleged sexual abuse of the child.</td>
</tr>
</tbody>
</table>

**Inter-rater agreement for the four child-related issues.** A second coder independently coded 20 (15%) reports. For the four types of child-related issues there was a 94% agreement rate between the coders for 80 codings \((k = .88, SE = .08)\). Disagreements were resolved by discussion.

**Assessment Issues**

One of the aims in analysing the clinicians’ reports was to identify the issues the clinicians noted in their reports. For each individual child, specific reasons for the assessment request were noted, addressing: ‘what is this assessment about?’

As far as can be determined, there has been no previous research on the specific assessment issues involved in court ordered clinic assessments, although some research
exist on the technical structure of the report or specific referral questions (e.g., Budd et al., 2001; Butler et al., 1995; Pellegrin & Wagner, 1990). The focus in these previous studies was based on referral questions from the court and they were concerned about the detailed structural content of clinical assessments such as the child’s developmental history or family functioning which are routinely assessed in all court clinic assessments (Brown, 1999).

In the current research, for 46% of the children there were one or more specific referral questions from the court. If the assessment had a specific request from the court that was initially used as an assessment issue the clinicians’ follow-up on that assessment issue was checked in the reports. The categories for assessment issues were based on specific information in the clinic reports themselves.

Assessment issues were distinguished on the basis of 5 issues that appeared to contribute to the safety of the child and their protective environment: (1) placement: a question of physical environment – where and with whom the child should live; (2) protective concerns: a specific issue/question of a problem contributing to the safety of the child in their current environment; access arrangements for either (3) the father or (4) the mother: a question of maintaining, re-establishing or reducing parent-child contacts; and (5) child specific problems: a question of how the child is coping in their current environment.

After establishing the initial coding categories for assessment issues, the Director of the court clinic was consulted on the development of the five categories for assessment issues. Then, an independent coder cross-coded 20 reports with a 98% agreement rate for 100 codings ($k = .96$, $SE = .04$).

**Clinicians’ Recommendations about Children’s Placements**

Each report concluded with recommendations to the court. In most reports these
were in dot points on the last page. Some recommendations were embedded in the summary of the assessment. Explicitly mentioned in each report were recommendations of children’s placement.

A child’s current placement was usually mentioned at the start of the report and the clinicians’ recommended placement at the end. These placements were subsequently cross-checked against the court’s Lex computerised data management system.

Placements were coded on a four-point scale ranging from 0 to 3 to reflect the child’s proximity with their biological parents as shown in Table 3.4. The same codifications were used for the current and recommended placement.

Table 4.4

Codifications of Child’s Current and Recommended Placement.

<table>
<thead>
<tr>
<th>Placement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of home care (foster or institutional)</td>
<td>0</td>
</tr>
<tr>
<td>Kinship care</td>
<td>1</td>
</tr>
<tr>
<td>Placement with one parent only</td>
<td>2</td>
</tr>
<tr>
<td>Placement with both parents (whether living together or not)</td>
<td>3</td>
</tr>
</tbody>
</table>

**STATISTICAL ANALYSES**

Analyses for Study 1 were conducted for each of the 250 children. Prior to formal analyses, the parent, child and court-related variables were examined using SPSS to ensure the distributions did not violate the assumptions of the statistical methods employed. For variables where significant skewness was detected, appropriate Log or Ln transformations were calculated. Binary variables where one coding involved more than 90% or less than 10% of the cases were excluded from the analyses. This is a
robust method to detect outliers for binary variables, as suggested by Rummel (1970). For categorical variables, the outliers were sought separately within each group.

To address *Research Question 1* concerning the patterns in the three types of identified parent problems, Hierarchical Cluster Analysis was used to form subgroups of children based on clinicians’ mentions of domestic violence, substance abuse and mental health problems in the father and the mother in the clinic assessments. The analyses confirmed 11 distinct cluster subgroups based on the problems of the parents that were also related to child, family and court factors. For this Cluster Analysis, Hair and Black’s (2000) six-step model-building approach was followed, involving Hierarchical Cluster Analysis using Ward’s method with a Squared Euclidean distance measure.

**Cluster Analysis**

Cluster Analysis is ideal for describing patterns in naturally occurring relationships by forming subgroups variables that theoretically may form patterns (Aldenderfer & Blashfield, 1984; Anderberg, 1973; Bailey, 1994; Green & Carroll, 1978; Punj & Stewart, 1983). Cluster analysis allows the researcher to investigate data in a ‘holistic’ way rather than isolating single variables that naturally occur together in the data. Figure 4.1 shows all the 6 stages of the analyses.
As Figure 4.1 shows, the similarity measure chosen for the current research was Squared Euclidean distance measure that is the most effective measure to minimise within-group and maximise between-group differences. After checking that the statistical assumptions were met, hierarchical algorithm with agglomerative procedure was appropriate for investigations of a group of binary variables. Ward’s method is the best clustering method to accompany this algorithm and procedure. In order to decide on the number of clusters, or the stopping rule, visual inspection of the dendrogram and the agglomeration schedule were followed.

The analysis yielded an optimal number of 11 clusters that best represented the patterns in parent problems. After deciding on the number of clusters, confirmatory examination of the clusters was employed. Given that hierarchical cluster analysis is sensitive to order effects (i.e. the sequential order the cases are presented in the data matrix), the clustering solution was confirmed by a split-half method that meant running
identical analysis for a randomly selected 50% of the sample (Hair & Brown, 2000; Henry, Tolan, & Gorman-Smith, 2005).

Non-Hierarchical K-Means Quick Cluster Analysis and Discriminant Function Analysis were subsequently used as confirmatory analyses to validate the cluster subgroups obtained by hierarchical clustering methods. These confirmatory analyses are generally followed and recommended in other research (Fisher & Ransom, 1995; Gorman-Smith, Tolan, & Henry, 2000; Henry et al., 2005), using hierarchical clustering methods. Separate Chi-square analyses were then used to examine the distributions of the three forms of parent problems for fathers and mothers across the clusters in order to describe the identifying patterns in the parent problems between the cluster subgroups. Finally, the clusters were assessed for dissimilarity between clusters using Chi-square Analysis in order to qualitatively describe the clusters.

Ideally, the optimal number of clusters represents underlying patterns in data, but related theoretical assumptions may also influence the decision about the stopping rule. For example, in the present analysis of 250 children, it was possible to find three ways to organise the groups of children based on the patterns of six forms of parent problem, as visual inspection of the dendrogram yielded possible clustering solutions at 7, 9 and 11-clusters. However, 7 or 9 cluster solutions contained less specific information about the patterns in the parent problems. In other words, it is important to consider how much information the specific set of variables can afford to lose, since the greater number of clusters means more specific information about the patterns they consist of.

The analyses for Research Question 2 examined how the 11 patterns of parent problems were associated with child-related issues; parents’ involvement in the assessment, assessment issues identified by clinicians, and clinicians’ placement
recommendations. Specifically, Analysis of Variance was used to examine whether the clusters were related to the child’s age and gender, as would be expected in a sample of children who were subjects of child protection matters.

Another Hierarchical Cluster Analysis was used to yield systematic patterns in the child-related issues: emotional and behavioural problems, neglect and alleged sexual abuse. Chi-square and Correspondence Analyses were then used to examine whether the 11 clusters were significantly associated with: (1) child-related clusters (systematic patterns between parent problems and child problems); (2) parents’ involvement in the assessment; (3) the assessment issues identified by clinicians; (4) children’s placements as they currently were; and (5) placements recommended by the clinicians.

Finally, Multiple Regression Analysis using a stepwise method was used to identify whether each parent problem, taken separately, and the assessment issues were significantly associated with the clinicians’ recommendations about placements. The stepwise method provides a step-by-step model where the first model only includes the highest correlated variable, with each subsequent model adding another independent variables until no further variables are significantly related to the dependent variable. As the placement predictors involved conceptually different variables (parent problems, assessment issues, current placement), to understand the structure of associations, it was important to compare the multiple models derived at each step.

**Summary**

This chapter presented the methodology for Study 1, including the procedure for retrieving and preparing the 138 clinic reports for analyses. It also addressed the methods of analyses that were used to examine the patterns in the problems of parents for 250 children for Research Question 1 and Research Question 2.
The next chapter, Chapter 5, addresses *Research Question 1*. Hierarchical Cluster Analysis was used to form distinct subgroups on the basis of three types of parent problems and allow for analyses of categorical and continuous variables to identify the distinct patterns related to the subgroups. The chapter describes the development of these cluster subgroups in more detail, including how they were inspected, culminating in a description of the cluster subgroups of the 250 children and how the six forms of parent problem variables were distributed across the clusters. Finally, theoretical and practical implications of the cluster subgroups are discussed.
Chapter 5

PATTERNS IN DOMESTIC VIOLENCE, SUBSTANCE ABUSE AND MENTAL HEALTH PROBLEMS OF PARENTS

This chapter addresses Research Question 1 for Study 1, which involved identifying the prevalence and patterns of three common forms of parental problem, domestic violence, substance abuse and mental health problems for biological fathers and mothers in the clinicians’ reports to the court. These analyses of 11 cluster subgroups of 250 children specifically aimed to:

(1) Establish the frequency with which clinicians mentioned each of these problems in relation to the biological fathers and mothers of children referred to the court clinic by the Children’s Court of Victoria; and

(2) Identify any systematic patterns of parent problems that clinicians mentioned in the reports.

The clusters were formed on the basis of the three types of problems for biological fathers and mothers, as they were given specific mention in the text of court clinic reports. Parent problems were classified using three categories, (1) Domestic Violence (DV); (2) Substance Abuse (SA); and (3) Mental Health (MH) problems for the biological father and mother of each of the 250 children. The analyses focused on identifying subgroups of children with distinctive forms of parental problems.

Hierarchical and non-hierarchical clustering techniques were used to identify subgroups of parent problems. The analyses yielded 11 distinctive and meaningful patterns in the parents’ problems. The development of these clusters is presented next, starting with the preferred technique: Hierarchical Cluster Analysis using Ward’s method, followed by K-Means non-hierarchical cluster analyses. A descriptive Discriminant Function Analysis was used to determine which of the six parent problem
variables best distinguished between the 11 subgroups and to discover the structure of the parent problem variables that were used to form the clusters. Chi-square analyses were used to examine the distribution of each parent problem across the 11 clusters. The chapter concludes with a description of the distribution of the parent problems in the cluster subgroups of the 250 children. The clusters are organised into four interpretable blocks with distinctive characteristics.

**Identifying Subgroups of Children based on Parents’ Problems**

Clusters were initially established by entering 3 parent problem variables (domestic violence, substance abuse, mental health problem) for each father and mother (6 variables in total) in the agglomeration schedule of a Hierarchical Cluster Analysis using Ward’s method with the Squared Euclidean distance measure. The agglomeration schedule revealed no single clear dramatic change in the coefficients between cluster solutions. Visual inspection of the dendrogram revealed that a cut-off point of no higher than 5 was needed to represent the optimal number of clusters. Cut-off points higher than 5 in the dendrogram tend to merge clusters that have a long distance between the cluster centres, and results in significant dissimilarity. The dendrogram plot showed possible clustering solutions of 11 (cut off point 3), 10 (cut-off point 4), and 7 (cut-off point 5) clusters. The 11-cluster solution offered the best interpretation of subgroup patterns and was therefore chosen for further analyses.

A confirmatory non-hierarchical K-Means cluster analysis was then computed for all variables, to check whether the non-hierarchical and hierarchical clustering techniques would classify the 250 children similarly. The two clustering techniques yielded similar patterns with 11-cluster solutions, but they were not in perfect agreement, such that both methods did not group the same children according to these 11 clusters. Three clusters (C1, C2, C6) were in a perfect agreement using Ward’s
hierarchical and the K-means non-hierarchical method. Two clusters (C7, C11) were clustered nearly in perfect agreement (greater than 90%) of cases and 3 subgroups (C4, C8, C10) were clustered with greater than 50% agreement in cluster membership. However, three subgroups (C3, C5 and C9) were clustered with less than 50% agreement by using the two clustering methods.

Hierarchical clustering methods are considered to be more robust than non-hierarchical clustering methods, such as K-Means Cluster Analysis, in generating clusters (Hair & Black, 2000). Non-hierarchical clustering techniques produce less reliable and stable cluster models (Datta & Datta, 2003). Therefore the cluster solution obtained using Ward’s method was chosen for further analyses. The comparison between the hierarchical and non-hierarchical clustering methods, however, shows which clusters show the highest degree of stability. Clusters C1, C2, C6, C7 and C11 appeared to be the most stable subgroups.

In addition, any sensitivity of the 11-cluster model to order effects was tested using two split-sample cross-validation analyses. A random 50% of the 250 children were withheld from calculation of the cluster analyses in these runs.

As shown in Table 5.1, the two cluster analyses used for 125 children yielded 11 clusters that were similar to the 11-cluster solution for the whole sample, revealing 92% and 94% correct classification rates, respectively. These results indicated a high degree of consistency in the clustering scheme.

The cluster subgroups that showed the greatest consistency in comparison to the K-Means Clustering outcomes, C1, C2, and C6, were clustered in perfect agreement in the two split-half analyses. The split-half analyses also yielded perfect agreement for clusters C4, C7, C8, and C10. On the basis of these analyses, the Wards Hierarchical
11-cluster solution was considered suitable for further analyses of patterns in the parent problems in relation to the 250 children.

Table 5.1

Percentages of Agreement between the Initial and Two Split-Half Hierarchical Cluster Analyses

<table>
<thead>
<tr>
<th>Cluster</th>
<th>1st random half (n=125) %</th>
<th>2nd random half (n=125) %</th>
<th>M (1st + 2nd) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1 ^</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C2 ^</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C3 d</td>
<td>91.20</td>
<td>91.70</td>
<td>91.45</td>
</tr>
<tr>
<td>C4 c</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C5 d</td>
<td>46.66</td>
<td>70.00</td>
<td>58.33</td>
</tr>
<tr>
<td>C6 a</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C7 b</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C8 c</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C9 d</td>
<td>72.73</td>
<td>72.73</td>
<td>72.73</td>
</tr>
<tr>
<td>C10 c</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C11 b</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Average % of 11 clusters 91.87 94.03 92.95

Note: Agreement with K-Means Cluster Analysis ^ = 100%; b > 90%; c >50%; d<50%

Discriminating Features of the Eleven Cluster Subgroups

Next, a descriptive Discriminant Function Analysis was used to examine the distinctive parent problems associated with the 11 cluster subgroups. While cluster analysis classifies unknown groups, Discriminant Function Analysis classifies known groups. It is useful as a confirmatory method for the groups yielded by cluster analysis, that is considered a more exploratory method of analysis.

The variable: ‘mother’s domestic violence’ failed the tolerance test (p < .01) and was therefore omitted from the analysis. Variables that fail the tolerance test represent an almost linear combination of other variables. The patterns in the omitted ‘mother’s domestic violence’ variable across the 11 cluster subgroups are addressed in the subsequent analyses by using a Chi-square Test of Equality of Distributions.
The Discriminant Function Analysis on the five remaining parent problems yielded five discriminant functions (DF) in the data that significantly distinguished between the 11 cluster subgroups. The combined Wilk’s Lambda Chi-Square for all five discriminating functions was, \( \chi^2(50, 250) = 1402.22, p = .00 \) indicating that the five discriminant functions together significantly distinguished between the 11 subgroups. After removing the first function (DF1), the four remaining functions significantly distinguished between the subgroups, \( \chi^2(36, 250) = 818.84, p = .00 \). This was also the case after removing the second (DF2), \( \chi^2(24, 250) = 465.76, p = .00 \), the third (DF3), \( \chi^2(14, 250) = 203.77, p = .00 \), and the fourth (DF4), \( \chi^2(6, 250) = 73.21, p = .00 \), discriminant functions.

The discriminating functions were: (1) father’s substance abuse accounting for 62% of the variance between clusters, (2) mother’s domestic violence and father’s substance abuse (20% of variance), (3) mother’s substance abuse and father’s domestic violence (12% of variance), and (4) mother’s mental health problems (4% of variance). The fifth discriminant function did not load significantly on any of the parent problems and only accounted for 2% of the variation between the 11 clusters. The description of the results is therefore focused on the four discriminating functions that significantly distinguished between the clusters.

Table 5.2 summarises the loadings for the 4 discriminant functions that accounted for nearly all of the variance (97.9%). The first column shows the makeup of each discriminating function by showing the parent problems that loaded strongly (>.33) on each DF. The loadings represent the correlations between the parent problems and DF’s. The last two columns show the Function Scores for the four clusters that had the strongest loadings for each DF.
Table 5.2

*Description of Four Discriminant Functions Differentiating between Eleven Cluster Subgroups*

<table>
<thead>
<tr>
<th>Discriminant Function (DF), (+ loadings/coefficients *)</th>
<th>% of variance</th>
<th>+ Function scores for clusters**</th>
<th>- Function scores for clusters **</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DF1:</strong> Father substance abuse (.91)</td>
<td>61.7</td>
<td>C11 (3.83)</td>
<td>C1 (-3.90)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C10 (3.66)</td>
<td>C6 (-3.25)</td>
</tr>
<tr>
<td><strong>DF2:</strong> Mother mental health (.78) and Father mental health (.40)</td>
<td>20.0</td>
<td>C8 (3.02)</td>
<td>C3 (-3.63)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C5 (1.90)</td>
<td>C1 (-2.20)</td>
</tr>
<tr>
<td><strong>DF3:</strong> Mother substance abuse (.80) and Mental health (.45)</td>
<td>11.8</td>
<td>C4 (2.25)</td>
<td>C7 (-2.24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C8 (-2.03)</td>
<td>C2 (-1.48)</td>
</tr>
<tr>
<td><strong>DF4:</strong> Father domestic violence (.92)</td>
<td>4.3</td>
<td>C2 (1.82)</td>
<td>C3 (-1.21)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>C9 (1.43)</td>
<td>C1 (-.89)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>97.9</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: * = Loadings for 6 parent problems and DF’s > .33; ** = Four highest loading cluster subgroups for each DF (+/-)

The first discriminant function (DF1) had positive loadings for father’s substance abuse. This function strongly distinguished two cluster subgroups with positive loadings (C10 and C11) from another two subgroups with negative loadings (C1 and C6).

The second discriminant function (DF2) had positive loadings for both parents’ mental health issues. This function distinguished two subgroups with positive loadings (C5 and C8) from two subgroups that had negative loadings (C1 and C3) for this function.

The third discriminant function (DF3) had negative loadings for mother’s substance abuse and mental health issues. This function distinguished one subgroup with positive loading (C4) from three subgroups with negative loadings (C2, C7, C8) on
mother’s substance abuse and mental health issues.

*The fourth discriminant function (DF4)* only had high loadings for father’s domestic violence. The function scores were significantly lower than those in DF1 through to DF3. This function distinguished two cluster subgroups with positive loadings (C2 and C9) from another two subgroups with negative loadings (C1 and C3).

In summary, the results of a Descriptive Discriminant Function Analysis revealed the distinctive parent problems associated with children in the 11 clusters. Substance abuse for father, mental health problems for both parents, and co-occurring substance abuse and mental health problems for mothers were the major parent problems that distinguished between the 11 cluster subgroups. Father’s domestic violence and mother’s mental health problems were the most prevalent parent problems in the sample, but they did not strongly discriminate between the clusters. Father’s substance abuse discriminated strongest between the 11 clusters, accounting for more than half of all the variance. Both parents’ mental health problems accounted for 20% of the variance, being the second strongest discriminating function between the clusters. Less prevalent, yet significant, was the third discriminating function that comprised mother’s substance abuse and mental health issues.

**Distribution of Six Parent Problems across 11 Cluster Subgroups**

To support and interpret the results from Discriminant Function Analysis, a set of individual Chi-square analyses was used to examine the distribution of the six parent problems across the 11 cluster subgroups. In describing the patterns of clinicians’ mentions of parent problems, Adjusted Standardised Residuals (ASRs) of six individual Chi-square analyses for each of the six parent problems were used to indicate the clinicians’ mentions of parent problems that were more or less frequent than the expected equal distribution across the 11 cluster subgroups.
The ASRs showed significantly different patterns of cell frequencies that were higher (ASRs > 2.0) or lower (ASRs < -2.0) than expected by the chi-square model as these values are conventionally used to identify cell values that are significantly higher or lower from the expected equal distribution of the Chi-Square model. Each cluster also contained parent problems that acted with as ‘expected’ patterns, i.e., the cell frequency was in the expected range of the Chi-square model.

*Father’s domestic violence* had ASRs above 2.0 for 4 of the 11 clusters (high mentions: C2, C6, C7, C8) and below -2.0 for 4 clusters (low mentions: C1, C3, C9, C10). For 3 clusters (C4, C5 and C11), the percentages of father’s domestic violence in each cell were in the expected range of the chi-square model, $\chi^2(10, 250) = 136.74, p = .00$.

*Father’s substance abuse* had ASRs above 2.0 for 5 of the 11 clusters (high mentions: C5, C7, C8, C10 and C11) and below -2.0 for 5 clusters (low mentions: C1, C3, C4, C6 and C9). For one cluster (C2), percentages of father’s substance abuse were in the expected range of the chi-square model, $\chi^2(10, 250) = 224.39, p = .00$.

*Father’s mental health problems* had ASRs above 2.0 for 4 of the 11 clusters (high mentions: C2, C5, C7 and C10) and below -2.0 for 6 clusters (low mentions: C1, C3, C4, C6, C8 and C9), indicating that there were relatively more clusters with fewer mentions of father’s mental health issues. There were 4 clusters (C3, C4 and C8) where percentages of father’s mental health were in the expected range of the chi-square model, $\chi^2(10, 250) = 157.99, p = .00$.

*Mother’s domestic violence* had ASRs above 2.0 for 3 of the 11 clusters (high mentions: C3, C8 and C10) and below -2.0 for 8 clusters (low mentions: C1, C2, C4, C5, C6, C7, C9 and C11) indicating that more clusters had relatively fewer mentions of mother’s domestic violence than expected by the chi-square model of equal distribution,
Mother’s domestic violence variable was omitted from the Discriminant Function Analysis, and it was therefore examined separately against the 11 clusters. The 70 (28% of all children) mentions of mother’s domestic violence were distributed differently across the 11 clusters, \( \chi^2 (10, 250) = 250.00, p = .00 \). It occurred in only three clusters, C6 (n=31; 7.2% of total), C9 (n=21; 8.4% of total), and C11 (n=18; 7.2% of total). There were no mentions of mother’s domestic violence in any of the remaining eight cluster subgroups. It seems that the distribution of mother’s domestic violence was the most unequal problem across the 11 clusters in comparison to all other five types of problems.

Mother’s substance abuse had ASRs above 2.0 for 4 of the 11 clusters (high mentions: C5, C8, C9 and C10) and below -2.0 for 4 clusters (low mentions: C1, C2, C4 and C6). For three clusters (C3, C7 and C11), the percentages of mother’s substance abuse were in the expected range of the chi-square model, \( \chi^2 (10, 250) = 171.44, p = .00 \).

Mother’s mental health problems had ASRs above 2.0 for 5 of the 11 clusters (high mentions: C2, C3, C4, C5, and C10) and below -2.0 for 4 clusters (low mentions: C1, C6, C7 and C11) across the 11 clusters. In 3 clusters (C4, C6 and C9), the percentages of mother’s mental health problems were in the expected range of the chi-square model, \( \chi^2 (10, 250) = 175.52, p = .00 \).

Figure 5.2 shows the distribution of the 6 parent problems across the 11 cluster subgroups of 250 children, described in terms of which parent problems had ‘more’, ‘fewer’, or ‘expected’ mentions for each cluster. Cells with fewer mentions (ASR ≤ -2.0) are assigned a blue arrow, cells that were in the expected range (2.0 > ASR < -2.0) a black arrow, and cells with more mentions (ASRs ≥ 2.0) a red arrow.
Figure 5.1 Distribution of parent problems across 11 cluster subgroups for 250 children.

At the top of Figure 5.1 is the cluster subgroup (C1) with no mentions of any of the 6 forms of parent problem, followed by clusters where only one parent problem was mentioned. Towards the bottom of Figure 5.2, there are clusters with increasingly more parent problems, first only for fathers and then only for mothers, followed by clusters where both parents have mentions of multiple problems. On the bottom, a cluster subgroup has mentions of all 6 types of problems, except father’s domestic violence which was still mentioned for 78% of all children.

In summary, the frequencies of clinicians’ mentions for the 6 parent problems across the 11 cluster subgroups were distributed differently from the expectation of an equal distribution, as specified by the chi-square model ($p \leq .01$). Although father’s domestic violence and mother’s mental health problems were the most frequently mentioned parent problems, the distribution of these two parent problems were the closest to the equal distribution across the 11 clusters. In addition, the results from Discriminant Function Analysis showed that father’s substance abuse, followed by both

<table>
<thead>
<tr>
<th>Cluster subgroup</th>
<th>FDV</th>
<th>MDV</th>
<th>FSA</th>
<th>MSA</th>
<th>FMH</th>
<th>MMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: No prob’s (n=18)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>C2: Fdv (n=16)</td>
<td>❌</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>C3: Fsa (n=20)</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>C4: Msa (n=22)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>C5: Mmh (n=29)</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C6: MdvMmh (n=31)</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C7: FdvFsaFmh (n=19)</td>
<td>✓</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C8: FdvFmhMmh (n=22)</td>
<td>✓</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C9: FdvFsaMdvMsa (n=21)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C10: FsaFmhMsaMmh (n=34)</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>C11: All Prob’s (n=18)</td>
<td>❌</td>
<td>❌</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

Note: F=father; M=Mother; dv = domestic violence; sa = substance abuse; mh = mental health problems.
parents’ mental health problems significantly distinguished between the 11 cluster subgroups. The six individual Chi-square analyses showed that the distribution of the mother’s domestic violence variable, which was eliminated from the Discriminant Function Analysis, across the 11 clusters, was furthest away from the expected equal distribution.

**Describing the Cluster Subgroups on Parent Problems**

The final step in confirming clusters was to examine the identifying parent problems for each of the 11 cluster subgroups. The 11 cluster subgroups are organised, for ease of interpretation and reporting, into four blocks. These four blocks reflect the complexity of parent problems, or lack thereof, in relation to the 250 children. The blocks were established by categorising 11 cluster subgroups, obtained from exploratory cluster analysis, into groups based on the complexity of parent problems in the clusters.

The four blocks involved: (Block 1) one cluster with no mentions of parent problems (C1); (Block 2) four clusters with one dominant mention of one parent problem (C2 - C5); (Block 3) two clusters with multiple problems mentioned for either the father (C7) or the mother (C6); and (Block 4) four clusters with multiple problems mentioned in relation to both parents (C8-C11). The 11 clusters and 4 blocks are described in Figure 5.2.

Figure 5.2 shows the defining parent problems for each of the 11 clusters with defining problems (column 2). A defining problem was identified as a parent problem which was mentioned in relation to 70% or more of the children in the cluster (e.g., C6 and C7 show defining problems other than 100%). Figure 5.2 also shows, in column 3, other problems associated with these clusters (e.g., C3 with 65% children associated with mother’s substance abuse and 5% associated with father’s mental health). The final column describes the labels for clusters used throughout the analyses for Study 1.
<table>
<thead>
<tr>
<th>C No.</th>
<th>Defining Parent Problems a</th>
<th>Other Parent Problems</th>
<th>Cluster label b</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Block 1 No parent problems:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1 (n=18)</td>
<td>No parent problems</td>
<td>None</td>
<td>C1: No pp</td>
</tr>
<tr>
<td><strong>Block 2 One dominant parent problem:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2 (n=16)</td>
<td>All 16 associated with Fdv</td>
<td>None</td>
<td>C2: Fdv</td>
</tr>
<tr>
<td>C3 (n=20)</td>
<td>All 20 associated with Fsa</td>
<td>65% Msa 5% Fmh</td>
<td>C3: Fsa</td>
</tr>
<tr>
<td>C4 (n=22)</td>
<td>All 22 associated with Msa</td>
<td>59% Mmh 36% Fdv</td>
<td>C4: Msa</td>
</tr>
<tr>
<td>C5 (n=29)</td>
<td>All 29 children associated with Mmh</td>
<td>59% with Fdv 10% with Fmh</td>
<td>C5: Mmh</td>
</tr>
<tr>
<td><strong>Block 3 Multiple problems for one parent:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C6 (n=31)</td>
<td>All 29 associated with Mdv 77% associated with Mmh</td>
<td>39% Msa 19% Fdv</td>
<td>C6: MdvMmh</td>
</tr>
<tr>
<td>C7 (n=19)</td>
<td>All 19 associated with Fdv 95% associated with Fsa</td>
<td>59% with Fmh 36% with Msa</td>
<td>C7: FdvFsa</td>
</tr>
<tr>
<td><strong>Block 4 Multiple problems for both parents:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C8 (n=22)</td>
<td>All 22 associated with Fdv All 22 associated with Fmh All 22 associated with Mmh</td>
<td>59% with Fsa</td>
<td>C8: FdvFmhMmh</td>
</tr>
<tr>
<td>C9 (n=21)</td>
<td>All 21 associated with Fdv All 21 associated with Fsa All 21 associated with Mdv All 21 associated with Msa</td>
<td>62% with Mmh</td>
<td>C9: FdvFsaMdvMsa</td>
</tr>
<tr>
<td>C10 (n=22)</td>
<td>All 22 associated with Fsa All 22 associated with Msa All 22 associated with Mmh</td>
<td>68% with FDV 50% with FMH</td>
<td>C10: FsaMsaMmh</td>
</tr>
<tr>
<td>C11 (n=18)</td>
<td>All 18 associated with Fsa All 18 associated with Mdv 78% associated with Fdv 89% associated with Fmh 72% associated with Msa 95% associated with Mmh</td>
<td>None</td>
<td>C11: all pp</td>
</tr>
</tbody>
</table>

*Note:* a = 70% or more children in cluster associated with that parent problem; b = label used in analyses, F = father; M = mother; dv = domestic violence; sa = substance abuse; mh = mental health problems.

*Figure 5.2* Defining parent problems and labels for 11 cluster subgroups.
Block 1 with no mentions of parent problems included one cluster (C1). Block 2 was defined by only one dominating (parent problems mentioned for more than 70% of the children) parent problem. Four types of parent problem were included in Block 2: two for fathers (domestic violence and substance abuse), and two for mothers (substance abuse and mental health problem). Block 3 only involved two clusters, one involved mental health and domestic violence for mothers, and the other domestic violence and substance abuse for fathers. The final block, Block 4, included the most concerning patterns of parent problems. The problems were mentioned in relation to both parents in each of the four clusters. The complexities in the families’ lives in Block 4 are also expected to play a role in clinicians’ recommendations about the children’s placements and protection orders. In particular, it seems reasonable to assume that the four blocks vary according to the level and types of complexity.

Summary

These analyses addressed the first research question, identifying patterns of occurrence and co-occurrence of parent problems in the clinicians’ assessments and reports to court. Taken together, the analyses led to the development of a detailed account of the parent problem configurations in 11 clusters. The clusters had distinct patterns in the parent problems that court clinic clinicians mentioned in their assessments.

The differences in the co-occurrence of parent problems between the clusters were substantial, thus, the description of each cluster subgroup identified 11 distinctive patterns in the co-occurrence of parent problems for 250 children in the reports made by the clinicians. The greatest contrast was between one cluster with no mentions of the problems (C1) and one with mentions of all the problems (C11).
The 11 clusters were organised into four blocks based on the complexity of parent problems yielded by cluster analyses. Block 1 had no mentions of parent problems and only involved one cluster (C1). Block 2 involved four clusters (C2, C3, C4, C5) that were characterised by only one dominant problem. Block 3 involved only two subgroups (C6, C7) involving domestic violence for either the father or the mother together with either substance abuse (father) or mental health problems (mother). Block 4 involved multiple parent problems, most of which included substance abuse for both parents (C9, C10, C11), although one only involved mentions of mental health problems for both parents and father domestic violence (C8). The last cluster, C11, entailed the most concerning pattern, including mentions of all the six types of parent problem. It was expected that children in this cluster would receive special attention in the clinic assessments.

The most prevalent problem in the data, father’s domestic violence, was a defining problem in four subgroups. It was present in all three blocks that involved mentions of parent problems: it appeared to be either a dominant problem (C2) or to co-occur with other father problems (C7), or complex problems for both parents (C8, C9).

Another prevalent parent problem, mother’s mental health issues, was also present in three blocks. It was a dominant problem (C5), or co-occurred with mother’s domestic violence (C6). When the mother’s mental health problems occurred with father problems in Block 4, father’s mental health problems were always present (C8, C10, C11).

Father’s substance abuse was the most prevalent parent problem when discriminating between the 11 clusters. It was present in three blocks. Mother’s substance abuse, however, was only present in two blocks, Block 2 and Block 4. It was either a dominant problem (C4) or co-occurred with father’s substance abuse. When
both parents’ substance abuse was mentioned in Block 4, it always co-occurred with varying patterns of other problems (C9, C10, C11).

Father’s mental health problem was the least prevalent problem in the clusters, being a defining problem in only one block (Block 4). It was only mentioned in conjunction with mother’s mental health problems (C8, C9, C11). Mother’s domestic violence was also less prevalent but it was involved in 2 blocks. (Block 3 with mother’s mental health problems (C6) and Block 4 with both parents’ domestic violence and substance abuse (C9) or with all other parent problems (C11).

These results and a closer inspection of the distribution of the 6 parent problems provide a firm basis to conclude that the 11 subgroups exist in the data. The subgroups show different and conceptually meaningful patterns of parent problems mentioned in the families referred to the clinic. How these patterns contribute to the clinicians’ interpretations and clinical recommendations about the placements of the 250 children is examined in the following chapter, Chapter 6.
Chapter 6

ASSOCIATIONS OF THE ELEVEN CLUSTER SUBGROUPS WITH CHILD AND FAMILY CHARACTERISTICS AND CLINICIANS’ RECOMMENDATIONS

This chapter addresses Research Question 2 for Study 1 which involved identifying the systematic ways in which the three common forms of parental problem (domestic violence, substance abuse and mental health problems) for biological fathers and mothers were related to other case factors that were relevant for the protection of children assessed at the Clinic. These analyses of 11 cluster subgroups of 250 children specifically aimed to identify whether the subgroups were associated with:

1. Clinicians’ mentions of child emotional and behavioural problems, neglect and allegations of sexual abuse;
2. Parents’ involvement in the clinic assessment;
3. Assessment issues identified by clinicians; and
4. Clinicians’ recommendations about children’s placements to the court.

These analyses follow from the identification of the patterns in the previous chapter, Chapter 5. The chapter first addresses specific aims (1), (2) and (3): how child-related issues, parents’ involvement and assessment issues identified by the court clinicians were distributed across the 11 cluster subgroups. The second part of the chapter concentrates on aim (4): how the 11 clusters were related to the current situations and clinicians’ recommendation about children’s placements. The analyses concentrate on the associations between the 11 cluster subgroups to other case characteristics. Where appropriate, and to structure the reporting, some of the analyses are presented within the four blocks (Block 1: No parent problems; Block 2: One parent...
problem; Block 3: Two parent problems; Block 4: Multiple parent problems) based on the complexity of parent problems in the clusters, as described in Chapter 5.

**ELEVEN CLUSTERS AND ASSOCIATIONS WITH CHILD-RELATED ISSUES AND PARENT INVOLVEMENT**

The analyses of 11 cluster subgroups for child and parent factors are presented for: (1) the child’s age and gender; (2) child-related issues including behavioural and emotional problems and mentions of sexual abuse and neglect; and (3) parents’ involvement in the clinic assessment.

**Child’s Age and Gender**

The court’s referrals of protective matters were not dependent on the age or gender of the child in question. Clinicians recorded in each report age in years and gender for all the 250 children. The mean ages for boys and girls in the 11 clusters are shown in the Table 6.1. An 11 cluster by 2 gender Analysis of Variance for a child’s age showed no significant differences in a child’s age across the 11 clusters, $F(10, 249)=1.65, p = .09, \eta^2=.00$, or gender, $F(1, 249) = .01, p = .96, \eta^2=.00$, and no interaction for cluster by gender, $F(10, 249) = 1.20, p = .26, \eta^2=.05$. There was wide variability in the ages of 250 children, as indicated by large standard deviations.

**Child-Related Issues**

Clinicians mentioned emotional or behavioural problems or both for 51% of the 250 children. The clinicians mentioned four types of child-related issues: emotional problems, 20%; behavioural problems, 38%; sexual abuse, 18%; and neglect, 41%. These four problems associated with child well-being were called ‘child-related issues’ for the purposes of further analyses.
Table 6.1

*Mean Age for Two-Hundred-and-Fifty Children in Eleven Cluster Subgroups*

<table>
<thead>
<tr>
<th>BLOCKS</th>
<th>CLUSTERS</th>
<th>Gender</th>
<th>M</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1: No PPs</td>
<td>C1:</td>
<td>Boys</td>
<td>6.78</td>
<td>4.08</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>No PPs</td>
<td>Girls</td>
<td>9.43</td>
<td>5.44</td>
<td>7</td>
</tr>
<tr>
<td>Block 2: 1 PP</td>
<td>C2:</td>
<td>Boys</td>
<td>8.81</td>
<td>3.01</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Fdv</td>
<td>Girls</td>
<td>7.38</td>
<td>3.43</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>C3:</td>
<td>Boys</td>
<td>8.31</td>
<td>4.84</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Fsa</td>
<td>Girls</td>
<td>6.78</td>
<td>2.86</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>C4:</td>
<td>Boys</td>
<td>9.14</td>
<td>5.30</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Msa</td>
<td>Girls</td>
<td>6.74</td>
<td>4.43</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>C5:</td>
<td>Boys</td>
<td>7.45</td>
<td>4.57</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Mmh</td>
<td>Girls</td>
<td>9.30</td>
<td>3.78</td>
<td>9</td>
</tr>
<tr>
<td>Block 3: 2 PPs</td>
<td>C6:</td>
<td>Boys</td>
<td>7.93</td>
<td>4.61</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>MdvMmh</td>
<td>Girls</td>
<td>6.80</td>
<td>5.82</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>C7:</td>
<td>Boys</td>
<td>5.53</td>
<td>3.70</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>FdvFsa</td>
<td>Girls</td>
<td>5.87</td>
<td>4.18</td>
<td>9</td>
</tr>
<tr>
<td>Block 4: Multiple PPs</td>
<td>C8:</td>
<td>Boys 8.89</td>
<td>4.27</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FdvFmhMmh</td>
<td>Girls 8.22</td>
<td>4.56</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C9:</td>
<td>Boys 4.44</td>
<td>3.78</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FdvFsa MdvMsa</td>
<td>Girls 5.87</td>
<td>4.49</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C10:</td>
<td>Boys 4.66</td>
<td>4.26</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FsaFmhMsaMmh</td>
<td>Girls 7.92</td>
<td>5.12</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C11:</td>
<td>Boys 8.23</td>
<td>4.20</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All probs</td>
<td>Girls 7.33</td>
<td>2.05</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Boys</td>
<td>7.52</td>
<td>4.49</td>
<td>145</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>7.27</td>
<td>4.37</td>
<td>105</td>
<td></td>
</tr>
</tbody>
</table>
The patterns in the child-related issues for 250 children were analysed using Hierarchical Cluster Analysis with Ward’s method and the Squared Euclidean distance measure. The analysis yielded six distinctive patterns of child-related issues. The development of the six clusters is described next.

**Six Child Cluster Subgroups for Child-Related Issues**

Clusters were established by entering four child-related issue variables in the agglomeration schedule of Hierarchical Cluster Analysis. The agglomeration schedule revealed no one clear dramatic change in the coefficients between cluster solutions. The dendrogram plot showed possible clustering solutions of 6 (cut-off point 5), 4 (cut-off point 7.5), and 2 (cut-off point 10) clusters. Upon closer inspection, the 6-cluster solution provided the largest between-group differences and was therefore chosen for further analyses.

Sensitivity of the 6-cluster model to order effects was tested by a split sample cross-validation. A random 50% of the 250 cases were withheld from calculation of the cluster analysis in this run. The cluster analysis for 125 (50%) cases yielded exactly the same clusters as the 6-cluster solution for the whole sample. For the 50% of cases for whom the functions were derived, there was a 100% correct classification rate.

**Discriminating features of six child-related issue cluster subgroups.**

Descriptive Discriminant Function Analysis was used to investigate differences between the six clusters on the basis of the four child-related variables on which the clusters were developed. The discriminant functions indicate which variables are the strongest predictors for the separation of groups obtained by the cluster-analytical approach. The analysis yielded four discriminant functions (DF) in the data that significantly corresponded to the composition of the six clusters.

The four DFs were: (1) sexual abuse (accounting for 51% of the variance
between the clusters); (2) neglect (28% of variance); (3) behavioural problems (16% of variance); and (4) emotional problems (5% of variance). These four DFs accounted for 100% of the variance between the six clusters. The combined Wilk’s Lambda Chi-Square for all discriminating functions was significant, \( \chi^2(20, 240) = 1393.41, p = .00 \), indicating that all four DFs significantly discriminated between the clusters. After removal of the first DF, the three remaining DFs still significantly discriminated between the six cluster subgroups, \( \chi^2(12, 240) = 857.64, p = .00 \). This was also the case after removing the second DF, \( \chi^2(6, 240) = 441.67 \ p = .00 \), and the third DF, \( \chi^2(2, 240) = 133.20 \ p = .00 \), leaving only the last DF in the model.

These four DFs were able to identify the strongest child-related issues contributing to group separation and they also seem to match adequately the patterns in the four child-related issues across the six clusters. DF 1 (sexual abuse) loaded highest (5.50) on Cluster 1, the only cluster that involved mentions of sexual abuse. DF 2 (neglect) loaded highest on Cluster 2 (2.22) and Cluster 4 (3.60), where Cluster 2 only involved mentions of neglect and Cluster 4 involved mentions of both neglect and behavioural problems. DF 3 (behavioural problems) loaded positively on Clusters 4 and 6, indeed, the latter only having mentions of behavioural problems. Finally DF 4 (emotional problems) loaded highest on Cluster 5, which only involved mentions of emotional problems.

**Descriptions of six child-related issue cluster subgroups.** Chi-Square analyses showed that the distributions of all four child problems across six cluster subgroups were significantly different from the expected equal distribution. Table 6.3 shows the percentages of distribution for: emotional problems, \( \chi^2(5, 245) = 133.67 \ p = .00 \); behavioural problems, \( \chi^2(5, 245) = 189.35 \ p = .00 \), neglect, \( \chi^2(5, 245) = 193.40 \ p = .00 \), and sexual abuse, \( \chi^2(2, 245) = 214.53 \ p = .00 \).
Table 6.2

Percentages of Child-Related Issues across Six Cluster Subgroups for Boys and Girls

<table>
<thead>
<tr>
<th>Child-Related Issue Cluster Subgroup</th>
<th>Emotional(^a)</th>
<th>Behavioral(^a)</th>
<th>Neglect(^a)</th>
<th>Sexual abuse(^a)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: Sex.abuse+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>32.1</td>
<td>57.1</td>
<td>25.0</td>
<td>85.7</td>
<td>49</td>
</tr>
<tr>
<td>Girls</td>
<td>52.4</td>
<td>52.4</td>
<td>52.4</td>
<td>95.2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>40.8(^b)</td>
<td>55.1(^b)</td>
<td>36.7</td>
<td>89.8(^b)</td>
<td></td>
</tr>
<tr>
<td>C2: Neglect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>3.8</td>
<td>0.0(^c)</td>
<td>100.0</td>
<td>0.0</td>
<td>50</td>
</tr>
<tr>
<td>Girls</td>
<td>0.0</td>
<td>0.0(^c)</td>
<td>100.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.0(^c)</td>
<td>0.0(^c)</td>
<td>100.0(^b)</td>
<td>0.0(^c)</td>
<td></td>
</tr>
<tr>
<td>C3: No issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>2.9</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>59</td>
</tr>
<tr>
<td>Girls</td>
<td>0.0</td>
<td>4.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1.7(^c)</td>
<td>1.7</td>
<td>0.0(^c)</td>
<td>0.0(^c)</td>
<td></td>
</tr>
<tr>
<td>C4: Behav.+Neglect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>3.8</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
<td>34</td>
</tr>
<tr>
<td>Girls</td>
<td>0.0</td>
<td>100.0</td>
<td>100.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2.9(^c)</td>
<td>100.0(^b)</td>
<td>100.0(^b)</td>
<td>0.0(^c)</td>
<td></td>
</tr>
<tr>
<td>C5: Emotional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>100.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>22</td>
</tr>
<tr>
<td>Girls</td>
<td>93.8</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>95.5(^b)</td>
<td>0.0(^c)</td>
<td>0.0(^c)</td>
<td>0.0(^c)</td>
<td></td>
</tr>
<tr>
<td>C6: Behavioral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>4.5</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>3.2</td>
<td>100.0(^b)</td>
<td>0.0(^c)</td>
<td>0.0(^c)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Boys                               | 13.4            | 45.1            | 42.1         | 16.4             | 245|
| Girls                              | 25.2            | 28.2            | 43.0         | 19.4             |    |
| Total                              | 18.4            | 38.0            | 42.5         | 18.4             |    |

Note: \(^a\) = \(\chi^2\) comparison of cluster subgroups significant, \(p < .05\); \(^b\) = ASR > 2.0; \(^c\) = ASR < -2.0.

Table 6.2 shows that in the first cluster (CC1: sex. abuse+), nearly all (90%) children had mentions of sexual abuse and 41% and 55% also had mentions of emotional and behavioural problems, respectively. All children in the second cluster (CC2: neglect) had mentions of neglect. Children in the third cluster (CC3: none) had close to no mentions of child-related issues. All children in the fourth cluster (CC4: behavioral, neglect) had mentions of behavioural problems and neglect. All children in the fifth cluster (CC5: emotional problems) had mentions of emotional problems, and all children in the sixth cluster (CC6: behavioural problems) had mentions of behavioural problems. The patterns of distribution are shown in Figure 6.1.
Figure 6.1 Distributions of clinicians’ mentions of child-related issues for six cluster subgroups.

The six clusters showed clear patterns of child-related issues where nearly all variables had significantly more or fewer mentions across the subgroups than would be expected from the chi-square model of equal distribution. Emotional problems were distributed closest to the expected equal distribution. Sexual abuse was mentioned only in one subgroup whereas three other child-related issues tended to occur alone for some children and also co-occur with other issues for others. Figure 6.1 shows the patterns in the four child-related issues that clinicians’ mentioned more (ASR > 2.0) and less (ASR < 2.0) frequently than expected.

Relating the Parent Problems and Child-Related Issues

Chi-Square analyses showed that the 6 child-related clusters were distributed in significantly different ways across the 11 parent problem clusters for all children

\[ \chi^2 (50, 245) = 124.90, p = .00 \]

and separately for boys, \[ \chi^2 (50, 245) = 109.31, p = .00 \]

and for girls, \[ \chi^2 (50, 245) = 71.09, p = .00 \]. The distributions of the six child-related issue clusters across the 11 parent problem clusters for boys and girls are illustrated in Table 6.3 and in Figure 6.2.
Table 6.3

Percentages of Six Child-Related Issue Clusters in Eleven Cluster Subgroups for Boys and Girls

<table>
<thead>
<tr>
<th>BLOCKS</th>
<th>CLUSTERS</th>
<th>Gender</th>
<th>CC1: Sex abuse</th>
<th>CC2: Neglect</th>
<th>CC3: No issues</th>
<th>CC4: Behav. Neglect</th>
<th>CC5: Emot.</th>
<th>CC6: Behav</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1:</td>
<td>C1: No PPs</td>
<td>Boys</td>
<td>36.4</td>
<td>9.1</td>
<td>18.2</td>
<td>9.1</td>
<td>18.2</td>
<td>9.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>42.9</td>
<td>0.0</td>
<td>28.6</td>
<td>0.0</td>
<td>28.6</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Block 2:</td>
<td>C2: 1 PP</td>
<td>Boys</td>
<td>66.7</td>
<td>22.2</td>
<td>0.0</td>
<td>11.1</td>
<td>0.0</td>
<td>0.0</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>57.1</td>
<td>14.3</td>
<td>0.0</td>
<td>0.0</td>
<td>14.3</td>
<td>14.3</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>C3: Fdv</td>
<td>Boys</td>
<td>8.3</td>
<td>33.3</td>
<td>8.3</td>
<td>41.7</td>
<td>0.0</td>
<td>8.3</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>12.5</td>
<td>12.5</td>
<td>50.0</td>
<td>0.0</td>
<td>0.0</td>
<td>25.0</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>C4: Fsa</td>
<td>Boys</td>
<td>0.0</td>
<td>14.3</td>
<td>71.4</td>
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<td>0.0</td>
<td>0.0</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>13.3</td>
<td>40.0</td>
<td>20.0</td>
<td>0.0</td>
<td>13.3</td>
<td>13.3</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>C5: Msa</td>
<td>Boys</td>
<td>26.3</td>
<td>15.8</td>
<td>26.3</td>
<td>0.0</td>
<td>21.1</td>
<td>0.0</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>22.2</td>
<td>11.1</td>
<td>33.3</td>
<td>11.1</td>
<td>11.1</td>
<td>0.0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Block 3:</td>
<td>C6: 2 PPs</td>
<td>Boys</td>
<td>16.7</td>
<td>11.1</td>
<td>16.7</td>
<td>5.6</td>
<td>11.1</td>
<td>38.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>8.3</td>
<td>0.0</td>
<td>16.7</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>C7: FdvFsa</td>
<td>Boys</td>
<td>20.0</td>
<td>0.0</td>
<td>40.0</td>
<td>20.0</td>
<td>10.0</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>22.2</td>
<td>33.3</td>
<td>33.3</td>
<td>11.1</td>
<td>11.1</td>
<td>0.0</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Block 4:</td>
<td>C8: Multiple PPs</td>
<td>Boys</td>
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<td>0.0</td>
<td>7.7</td>
<td>0.0</td>
<td>0.0</td>
<td>30.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>66.7</td>
<td>0.0</td>
<td>16.7</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>C9: FdvFsaMdMmh</td>
<td>Boys</td>
<td>0.0</td>
<td>12.5</td>
<td>12.5</td>
<td>75.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>7.7</td>
<td>53.8</td>
<td>7.7</td>
<td>15.4</td>
<td>15.4</td>
<td>0.0</td>
<td>0.0</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>C10: FsaMdMmh</td>
<td>Boys</td>
<td>0.0</td>
<td>26.1</td>
<td>47.8</td>
<td>13.0</td>
<td>0.0</td>
<td>36.4</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>9.1</td>
<td>18.2</td>
<td>36.4</td>
<td>0.0</td>
<td>0.0</td>
<td>36.4</td>
<td>0.0</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>C11: FsaMmhMsa</td>
<td>Boys</td>
<td>0.0</td>
<td>41.7</td>
<td>16.7</td>
<td>25.0</td>
<td>8.3</td>
<td>8.3</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>0.0</td>
<td>50.0</td>
<td>33.3</td>
<td>16.7</td>
<td>16.7</td>
<td>0.0</td>
<td>0.0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>Boys</td>
<td>19.7</td>
<td>18.3</td>
<td>23.9</td>
<td>18.3</td>
<td>4.2</td>
<td>15.5</td>
<td></td>
<td>145</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>20.4</td>
<td>23.3</td>
<td>24.3</td>
<td>7.8</td>
<td>15.5</td>
<td>8.7</td>
<td></td>
<td>105</td>
</tr>
</tbody>
</table>

Note: * = \( \chi^2 \) comparison of cluster subgroups significant, \( p < .05 \); \( \text{b} = \text{ASR} > 2.0 \)
Figure 6.2 Percentages for 145 boys and 105 girls across 6 child-related issue clusters for 11 parent problem cluster subgroups.
The results about the associations between the 6 child-related subgroups and 11 parent problem subgroups are reported next for 4 blocks based on the complexity of parent problems, as specified in Chapter 5. The ASRs reported here are derived from the Chi-square analyses for 11 by 6 clusters, for boys and girls, respectively.

**Block 1: No parent problems.** Table 6.3 shows that there were more boys with emotional problems (CC5) in C1 (no parent problems; ASR = 2.4). While not significantly different from other parent problem clusters for boys and girls separately, the total ASR = 2.1, has both boys and girls shows that there were significantly more children with mentions of sexual abuse (CC1) in C1.

**Block 2: One parent problem.** There were significantly more boys and more girls with mentions of sexual abuse in C2 (Fdv; ASRs = 3.7; 2.5).

**Block 3: Two parent problems.** There were significantly more boys and more girls than expected with behavioural problems (CC6) in C6 (MdvMmh; ASR = 2.9; 2.1).

**Block 4: Multiple parent problems.** There were significantly more boys and girls with mentions of sexual abuse in C8 (FdvFmhMdvMmh; ASRs = 3.2; 2.9). There were significantly more boys with mentions of neglect in C11 (all problems; ASR = 2.2) and more girls with mentions of neglect (CC2) in C9 (FdvFsaMdvMsa; ASR = 2.8). There were more boys than expected who had no mentions of child-related issues (CC3) in C10 (FsaFmhMsaMmh; ASR = 3.0). Significantly more boys with co-occurring neglect and behavioural problems (CC4) were in C9 (ASR = 4.3) and more girls in C10 (FsaFmhMsaMmh; ASRs = 2.0).

In summary, child-related issues were significantly associated with the 11 parent problem subgroups organised in the 4 blocks. Overall, there were more mentions of child related problems in Block 4 (with mentions of multiple parent problems). Problems for the mother were related to child behavioural problems, whereas multiple
parent problems were related to neglect. Sexual abuse occurred in 3 blocks, either in the absence of parent problems, or when father domestic violence was the only defining problem, or when father’s domestic violence co-occurred with both parents’ mental health issues. Boys’ emotional problems seemed to be associated with the absence of parent problems, while girls’ emotional problems were linked to mother’s co-occurring substance abuse and mental health problems.

**Perpetrators of Sexual Abuse**

Sexual abuse of a child was mentioned for 18% \( (n=45) \) of the 250 children. It was mentioned mostly in 3 clusters: C1 (no problems; 33%); C2 (Fdv; 56%); and C8 (FdvFmhMmh; 59%) and in 10 clusters, overall (all except C11). It was not obvious, however, if this was parent-initiated abuse or not. Therefore, a separate analysis was made of the alleged perpetrators of sexual abuse in the reports according to the four blocks. Chi-Square analysis showed that the four blocks had significantly different patterns of perpetrators mentioned in the reports, \( \chi^2 (6, 43) = 20.93, p = .01 \).

Figure 6.3 shows the alleged perpetrators of sexual abuse for the four blocks. Children in Block 1 and Block 2, involving clusters with a mention of no or one parent problem (C1-C5), only had mentions of sexual abuse by someone in the immediate family (i.e., father, mother, siblings) or the mother’s partner (i.e., not the biological father). Children in Block 1 were mostly abused by immediate family (83%) but also mother’s partner (17%). Children in Block 2 were also abused by immediate family members (39%) and mother’s partner (61%). Children in Block 3 were abused by immediate family (20%) or non-family members (80%). Children in Block 4 were most likely to have been abuse by immediate family (57%). Only children in Block 3 and Block 4, involving clusters with co-occurring parent problems (C6-C10), were abused
by someone outside immediate family, Block 3 in particular, showing that 80% of possible perpetrators were non-family members.

![Diagram](image)

**Figure 6.3** Percentages of children in four blocks associated with three types of alleged perpetrators of sexual abuse.

In summary, for children in families where there was no or only one type of parent problem present (Block 1 and Block 2), the alleged perpetrator was more likely to be in the immediate family. The perpetrator was most likely to be the mother’s partner in families with mentions of only one parent problem. When there were mentions of multiple parent problems, the perpetrators were someone other than a family member. It may be that in families with multiple problems, the parents are more vulnerable to sexual predators or unable to protect their child from the dangers in the environment due to their complex personal issues.
Parents’ Involvement in the Assessment

The involvement of parents in the clinic assessments was examined next. Given that each notification of the assessment involves an invitation for both biological parents to be present on the assessment day, it was important to identify which parents were able to attend and whether their involvement was associated with the patterns in the parent problems. Table 6.4 shows the patterns of parental involvement across 11 cluster subgroups.

Table 6.4
Percentages of Parent Involvement for Two-Hundred-and-Fifty Children in Eleven Cluster Subgroups

<table>
<thead>
<tr>
<th>BLOCK</th>
<th>Cluster Subgroup</th>
<th>No parents $^a$</th>
<th>One parent $^a$</th>
<th>Both parents $^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No PPs</td>
<td>C1: No PPs</td>
<td>22.2 $^b$</td>
<td>22.2</td>
<td>55.6</td>
</tr>
<tr>
<td>Block 2:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 PP</td>
<td>C2: Fdv</td>
<td>18.8 $^b$</td>
<td>18.8</td>
<td>62.5</td>
</tr>
<tr>
<td></td>
<td>C3: Fsa</td>
<td>15.0 $^b$</td>
<td>60.0 $^b$</td>
<td>25.0 $^c$</td>
</tr>
<tr>
<td></td>
<td>C4: Msa</td>
<td>4.5</td>
<td>59.1 $^b$</td>
<td>36.4 $^c$</td>
</tr>
<tr>
<td></td>
<td>C5: Mmh</td>
<td>6.9</td>
<td>37.9</td>
<td>55.2</td>
</tr>
<tr>
<td>Block 3:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 PPs</td>
<td>C6: MdvMmh</td>
<td>0.0</td>
<td>58.1 $^b$</td>
<td>41.9</td>
</tr>
<tr>
<td></td>
<td>C7: FdvFsa</td>
<td>0.0</td>
<td>57.9</td>
<td>42.1</td>
</tr>
<tr>
<td>Block 4:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple PPs</td>
<td>C8: FdvFmhMmh</td>
<td>0.0</td>
<td>4.5 $^c$</td>
<td>95.5 $^b$</td>
</tr>
<tr>
<td></td>
<td>C9: FdvFsa MdvMsa</td>
<td>0.0</td>
<td>38.1</td>
<td>61.9</td>
</tr>
<tr>
<td></td>
<td>C10: FsaFmhMsaMmh</td>
<td>2.9</td>
<td>38.2</td>
<td>58.8</td>
</tr>
<tr>
<td></td>
<td>C11: All PPs</td>
<td>0.0</td>
<td>5.6 $^c$</td>
<td>94.4 $^b$</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>5.6</td>
<td>38.0</td>
<td>56.4</td>
</tr>
</tbody>
</table>

*Note:* $^a = \chi^2$ comparison of cluster subgroups significant, $p < 0.05$; $^b = ASR > 2.0$; $^c = ASR < -2.0$.

For 56% of children, both parents were involved in the assessment (i.e., came to the clinic and took part in the clinic interviews). For another 38%, one parent was involved (mother only 30%, father only 8%). No biological parents were involved in the
assessment procedures for 6% of the children. Chi-square analysis showed that cluster
differences for biological parents’ involvement in the clinic assessment were significant,
\( \chi^2 (20, 250) = 66.08, p = .00. \)

Table 6.4 shows different patterns for the 4 blocks of children. While not all the
subgroups deviated from the expected Chi-square model of equal distribution, parents
who had multiple problems were more likely to come to the assessment in comparison
to other parents. Parents with no or only father’s domestic violence problems were less
likely to attend on the assessment day. The specific patterns in parents’ involvement are
reported next for the 11 clusters organised in the 4 blocks.

**Block 1: No parent problems.** There were more children than expected with
neither of their biological parents involved in C1 (No PPs, ASR = 3.2).

**Block 2: One parent problem.** More children with neither father nor mother
involved were also in C2 (Fdv, ASR = 2.4). More children with only one parent
involved were in C3 (Fsa, ASR = 2.1) and C4 (Msa, ASR = 2.1).

**Block 3: Two parent problems.** More children with only one parent involved
were in C6 (MdvMmh, ASR = 2.5).

**Block 4: Multiple parent problems.** There were more children than expected
with both parents involved in C8 (FdvFmhMmh, ASR = 3.9) and in C11 (all PPs, ASR =
3.4).

It was important to check if the parent who participated in the assessment was
the parent with the problem. Therefore, the 95 children with only one parent involved in
the assessment were selected for more detailed examination. Another Chi-Square
analysis of the 95 children who came to the assessment with either father or mother
showed that the 11 cluster subgroups differed significantly for only father and only
mother involvement, $\chi^2(10, 95) = 36.73, p = .00$. Figure 6.4 shows the patterns of involvement across the 11 clusters.

![Figure 6.4](image)

**Figure 6.4** Involvement of fathers and mothers across 11 cluster subgroups for 95 children who only had one parent involved in the assessment.

Figure 6.4 shows that while mothers, in general, came to the assessments more frequently than fathers, in three subgroups, C2 (Fdv ASR = 2.1), C7 (FdvFsaFmh, ASR = 4.6), and C8 (FdvFmhMmh, ASR = 2.0) fathers were significantly more likely to be present than mothers.

In sum, children in Block 1, without mentions of parent problems, were more likely to attend the assessment without their biological parents (C1). Children in two subgroups belonging to Block 2, where substance abuse was the only identifying parent problem, were likely to have only their mother present in the assessment (C3: Fsa; C4: Msa). Children in two subgroups belonging to Block 4, both of which had mentions of co-occurring father’s and mother’s mental health problems, were more likely to have both parents present in the assessment (C8: FdvFmhMmh; C11: All PPs).
ELEVEN CLUSTERS AND ASSESSMENT ISSUES

As discussed in Chapter 3, experienced clinicians have common issues that they focus on in their assessments. Five assessment issues were identified in the reports: (1) children’s placement; (2) specific protective concerns (e.g., investigations of abuse, neglect); (3) a child’s access to fathers; and (4) a child’s access to mothers; and (5) child problems (i.e., the assessment was focused around specific child-related issues impacting on the protective concerns). Table 6.5 shows the distribution of these 5 assessment issues for boys and girls.

Table 6.5
Percentages of Five Assessments Issues for Boys and Girls

<table>
<thead>
<tr>
<th>Assessment Issue</th>
<th>Boys %</th>
<th>Girls %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement Issue *</td>
<td>78.6</td>
<td>88.6</td>
<td>82.8</td>
</tr>
<tr>
<td>Protective Concerns</td>
<td>79.3</td>
<td>81.9</td>
<td>80.4</td>
</tr>
<tr>
<td>Access Father</td>
<td>39.3</td>
<td>37.1</td>
<td>38.4</td>
</tr>
<tr>
<td>Access Mother</td>
<td>51.0</td>
<td>55.2</td>
<td>52.8</td>
</tr>
<tr>
<td>Child Problems</td>
<td>41.4</td>
<td>34.3</td>
<td>38.4</td>
</tr>
</tbody>
</table>

*Note: * = $\chi^2$ comparison of boys and girls significant, $p < .05$

Table 6.6 shows that the 11 cluster subgroups were significantly associated with the 5 assessment issues, placement issues, protective concerns, access arrangements for fathers and mothers and child problems. Chi-Square analyses showed that the distribution of the five assessment issues differed significantly across 11 subgroups for placement issue $\chi^2 (10, 250) = 42.84$, $p = .00$, protective concerns, $\chi^2 (10, 250) = 29.42$, $p = .00$, access for father, $\chi^2 (10, 250) = 37.71$, $p = .00$, access for mother, $\chi^2 (20, 250) = 21.03$, $p = .00$, and child-specific problems, $\chi^2 (20, 250) = 32.60$, $p = .00$. The distribution of the five assessment issues for boys and girls across the 11 clusters is reported next in four blocks.
Table 6.6

Percentages of Five Assessments Issues in Eleven Cluster Subgroups for Boys and Girls

<table>
<thead>
<tr>
<th>BLOCKS</th>
<th>Cluster Subgroup</th>
<th>Placement %</th>
<th>Prot. Concerns %</th>
<th>Access Father %</th>
<th>Access Mother %</th>
<th>Child Probs. %</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1:</td>
<td>C1: No PPs</td>
<td>Boys</td>
<td>54.5&lt;sup&gt;c&lt;/sup&gt;</td>
<td>72.7</td>
<td>18.2</td>
<td>27.3</td>
<td>45.5</td>
</tr>
<tr>
<td>No PPs</td>
<td>Girls</td>
<td>42.9&lt;sup&gt;c&lt;/sup&gt;</td>
<td>85.7</td>
<td>14.3</td>
<td>0&lt;sup&gt;c&lt;/sup&gt;</td>
<td>14.3</td>
<td>18</td>
</tr>
<tr>
<td>Block 2:</td>
<td>C2: Fdv</td>
<td>Boys</td>
<td>100.0</td>
<td>33.3&lt;sup&gt;c&lt;/sup&gt;</td>
<td>44.4</td>
<td>22.2</td>
<td>55.6</td>
</tr>
<tr>
<td>1 PP</td>
<td>Girls</td>
<td>100.0</td>
<td>57.1</td>
<td>71.4</td>
<td>42.9</td>
<td>71.4</td>
<td>16</td>
</tr>
<tr>
<td>C3: Fsa</td>
<td>Boys</td>
<td>100.0</td>
<td>66.7</td>
<td>8.3&lt;sup&gt;c&lt;/sup&gt;</td>
<td>41.7</td>
<td>8.3&lt;sup&gt;c&lt;/sup&gt;</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>100.0</td>
<td>62.5</td>
<td>25.0</td>
<td>62.5</td>
<td>37.5</td>
<td>20</td>
</tr>
<tr>
<td>C4: Msa</td>
<td>Boys</td>
<td>100.0</td>
<td>85.7</td>
<td>0&lt;sup&gt;c&lt;/sup&gt;</td>
<td>71.4</td>
<td>42.9</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>100.0</td>
<td>66.7</td>
<td>0&lt;sup&gt;c&lt;/sup&gt;</td>
<td>46.7</td>
<td>33.3</td>
<td>20</td>
</tr>
<tr>
<td>C5: Mmh</td>
<td>Boys</td>
<td>90.0</td>
<td>70.0</td>
<td>60.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>55.0</td>
<td>75.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>88.9</td>
<td>77.8</td>
<td>44.4</td>
<td>66.7</td>
<td>44.4</td>
<td>20</td>
</tr>
<tr>
<td>Block 3:</td>
<td>C6: MdvMmh</td>
<td>Boys</td>
<td>94.7</td>
<td>89.5</td>
<td>31.6</td>
<td>57.9</td>
<td>52.6</td>
</tr>
<tr>
<td>2 PPs</td>
<td>Girls</td>
<td>91.7</td>
<td>83.3</td>
<td>8.3&lt;sup&gt;c&lt;/sup&gt;</td>
<td>58.3</td>
<td>41.7</td>
<td>24</td>
</tr>
<tr>
<td>C7:</td>
<td>FdvFsa</td>
<td>Boys</td>
<td>70.0</td>
<td>90.0</td>
<td>30.0</td>
<td>20.0&lt;sup&gt;c&lt;/sup&gt;</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>100.0</td>
<td>77.8</td>
<td>77.8&lt;sup&gt;b&lt;/sup&gt;</td>
<td>66.7</td>
<td>33.3</td>
<td>24</td>
</tr>
<tr>
<td>Block 4:</td>
<td>C8: FdvFmhMmh</td>
<td>Boys</td>
<td>64.3</td>
<td>100.0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>50.0</td>
<td>42.9</td>
<td>50.0</td>
</tr>
<tr>
<td>Multiple PPs</td>
<td>Girls</td>
<td>100.0</td>
<td>100.0</td>
<td>37.5</td>
<td>69.2</td>
<td>62.5</td>
<td>22</td>
</tr>
<tr>
<td>C9:</td>
<td>FdvFsa MdvMsa</td>
<td>Boys</td>
<td>62.5</td>
<td>100.0</td>
<td>37.5</td>
<td>62.5</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>69.2&lt;sup&gt;c&lt;/sup&gt;</td>
<td>92.3</td>
<td>61.5</td>
<td>69.2</td>
<td>23.1</td>
<td>21</td>
</tr>
<tr>
<td>C10:</td>
<td>FsaFmhMsaMmh</td>
<td>Boys</td>
<td>78.3</td>
<td>78.3</td>
<td>56.5</td>
<td>69.6</td>
<td>17.4&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>90.9</td>
<td>100.0</td>
<td>45.5</td>
<td>72.7</td>
<td>18.2</td>
<td>30</td>
</tr>
<tr>
<td>C11:</td>
<td>All probs</td>
<td>Boys</td>
<td>41.7&lt;sup&gt;c&lt;/sup&gt;</td>
<td>83.3</td>
<td>50.0</td>
<td>66.7</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Girls</td>
<td>88.6</td>
<td>100.0</td>
<td>50.0</td>
<td>50.0</td>
<td>0</td>
<td>18</td>
</tr>
</tbody>
</table>

Total | 18.4 | 38.0 | 42.5 | 18.4 | 38.4 | 250 |

Note: <sup>a</sup> = \( \chi^2 \) comparison of cluster subgroups significant, \( p < .05 \); <sup>b</sup> = ASR > 2.0; <sup>c</sup> = ASR < - 2.0.
**Block 1: No parent problems.** Clinicians identified significantly fewer placement issues for boys and girls in C1 (no PPs, \( ASR = -2.0 \) and \(-3.9\)). There were no other outstanding assessment issues in relation to children in C1.

**Block 2: One parent problem.** As shown in Table 6.6, clinicians identified significantly more placement issues than expected for boys and in C3 (Fsa, \( ASR = 2.0 \)). There were significantly more assessments of access arrangements for father in relation to boys in C5 (Mmh, \( ASR = 2.0 \)) but fewer for boys in C3 (Fsa, \( ASR = -2.3 \)) and fewer for both boys and girls in C4 (Msa, \( ASR = -2.2; -3.2 \)). There were significantly fewer assessments of protective concerns than expected for boys in C2 (Fdv, \( ASR = -3.5 \)). Finally, there were more assessment issues of child problems for boys in C5 (Mmh, \( ASR = 3.3 \)) but fewer for boys in C3 (Fsa \( ASR = -2.4 \)).

**Block 3: Two parent problems.** Clinicians identified significantly more assessments of access arrangements for father in relation to girls in C7 (FdvFsa, \( ASR = 2.6 \)) but fewer assessments for access arrangements about access for mothers in relation to boys in C7 (\( ASR = -2.0 \)).

**Block 4: Multiple parent problems.** Clinicians identified significantly fewer placement issues for girls in C9 (FdvFsaMdvMsa, \( ASR = -2.3 \)) and boys in C11 (all PPs, \( ASR = -3.3 \)). There were more assessment issues of access arrangements for mother in relation to boys in C10 (FsaFmhMsaMmh, \( ASR = 2.0 \)). There were significantly more assessments of protective concerns than expected for boys in C8 (FdvFmhMmh, \( ASR = 2.0 \)). Fewer assessment issues of child specific problems were identified for boys in C10 (\( ASR = -2.5 \)) and for all children in C11 (\( ASR = -2.5 \)).

In sum, these results suggest that assessments of placement issues are common when one parent has the problem. It was also less likely that access arrangements for fathers were the focus in these one parent problem families. Access arrangement for
both parents, mothers in particular, were more frequent in relation to multiple parent problems. Children of parents with multiple problems were also less likely to be assessed for child specific problems.

**CLINICIANS’ RECOMMENDATIONS TO THE COURT ABOUT CHILDREN’S PLACEMENTS**

Placement recommendations are important parts of the reports that clinicians provide to the court as expert input regarding the child’s best interests. It was of particular interest whether clinicians recommended many changes in the current situations. The foci of the next analyses were how the 11 patterns in the parent problems were associated with the comparisons between current and recommended placements.

**Eleven Clusters in Relation to Current and Recommended Children’s Placements**

Of all the 250 children, 30% were currently living in out of home care, 35% in kinship care, 14% in one parent’s care and 12% in both parents’ care. Clinicians recommended placements for only 246 children. Their recommendations were for 31% to reside in out of home care, 28% in kinship care, 25% in one parent’s care and 16% in both parents’ care.

**Current Placement**

Chi-Square analysis revealed that the 11 cluster subgroups were significantly associated with the current placements, $\chi^2(30, 249) = 67.93, p = .00$. The distribution of children in 11 subgroups across the four placements is shown in Table 6.7. Again, the distribution of four current placements is reported in the four blocks based on the complexity of parent problems in each cluster.

**Block 1: No parent problems.** Significantly more children than expected were living with both parents in C1 (no PPs, $ASR = 3.0$). Although not significantly different from the expected equal distribution, equally many children (33%) were also living in
out of home care. Fewer children were in kinship care (17%) or in one parent care (17%).

Table 6.7  
Percentages of Current Placements for Eleven Cluster Subgroups for Two-Hundred-and-Fifty Children

<table>
<thead>
<tr>
<th>Cluster Subgroup</th>
<th>Out of home %</th>
<th>Kinship %</th>
<th>One parent %</th>
<th>Both parents %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Block 1: No PPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1: No probs</td>
<td>33.3</td>
<td>16.7</td>
<td>16.7</td>
<td>33.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Block 2: 1 PP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C2: Fdv</td>
<td>62.5</td>
<td>25.0</td>
<td>0.0</td>
<td>12.5</td>
<td>100.0</td>
</tr>
<tr>
<td>C3: Fsa</td>
<td>45.0</td>
<td>35.0</td>
<td>0.0</td>
<td>20.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C4: Msa</td>
<td>27.3</td>
<td>54.5</td>
<td>13.6</td>
<td>4.5</td>
<td>100.0</td>
</tr>
<tr>
<td>C5: Mmh</td>
<td>51.7</td>
<td>13.8</td>
<td>24.1</td>
<td>10.3</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Block 3: 2 PPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C6: MdvMmh</td>
<td>33.3</td>
<td>40.0</td>
<td>26.7</td>
<td>0.0</td>
<td>100.0</td>
</tr>
<tr>
<td>C7: FdvFsaFmh</td>
<td>42.1</td>
<td>26.3</td>
<td>10.5</td>
<td>21.1</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Block 4: Multiple PPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C8: FdvFmhMmh</td>
<td>40.9</td>
<td>18.2</td>
<td>27.3</td>
<td>13.6</td>
<td>100.0</td>
</tr>
<tr>
<td>C9: FdvFsa MdvMsa</td>
<td>19.0</td>
<td>71.4</td>
<td>0.0</td>
<td>9.5</td>
<td>100.0</td>
</tr>
<tr>
<td>C10: FsaFmhMsaMmh</td>
<td>26.5</td>
<td>55.9</td>
<td>14.7</td>
<td>2.9</td>
<td>100.0</td>
</tr>
<tr>
<td>C11: All probs</td>
<td>50.0</td>
<td>11.1</td>
<td>22.2</td>
<td>16.7</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38.2</td>
<td>34.9</td>
<td>15.3</td>
<td>11.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: $^a = ASR > 2.0; ^b = ASR < -2.0.$

**Block 2: One parent problem.** There were significantly more children than expected currently in out of home care in C2 (Fdv, $ASR = 2.1$). No children were living in one parent care in C3 (Fsa, $ASR = -2.0$). There were more children than expected in kinship care in C4 (Msa, $ASR = 2.0$).

**Block 3: Two parent problems.** Fewer children than expected were living with both parents in C6 (MdvMmh, $ASR = -2.1$). Otherwise the current placements were equally distributed across the four placements for children who had multiple problems.
mentioned for fathers or mothers.

**Block 4: Multiple parent problems.** Significantly more children were currently in relatives’ care in C9 (FdvFsaMdvMsa, \( ASR = 3.7 \)) and C10 (FsaFmhMsaMmh, \( ASR = 2.8 \)), clusters that involved mentions of both parents’ substance abuse. Fewer children, however, were living in one parent care in C9 (FdvFsaMdvMsa, \( ASR = -2.0 \)). Fewer children were living in kinship care in C11 (all PPs, \( ASR = -2.2 \)).

**Recommended Placement**

The distribution of 11 clusters across the four placement recommendations was examined next. As shown in Table 6.8, Chi-Square analysis revealed that the 11 cluster subgroups were significantly associated with the clinicians’ recommended placements, \( \chi^2 (30, 246) = 66.15, p = .00 \).

**Block 1: No parent problems.** Fewer children than expected were recommended to kinship care in C1 (no PPs, \( ASR = -2.2 \)) but more to both parents’ care (\( ASR = 2.3 \)).

**Block 2: One parent problem.** Similar to the current placement, more children than expected were recommended to live in out of home care in C2 (Fdv, \( ASR = 2.5 \)). Children in other clusters with only one defining parent problem were equally distributed across the four placement recommendations.

**Block 3: Two parent problems.** The two clusters with mentions of two parent problems for either the father or the mother were equally distributed across the recommended placements.

**Block 4: Multiple parent problems.** There were fewer children than expected that clinicians recommended to out of home care in C9 (FdvFsaMdvMsa, \( ASR = -2.5 \)). Similar to the current placement, more children than expected were recommended to
kinship care in C9 (FdvFsaMdvMsa, ASR = 2.5) and C10 (FsaFmhMsaMmh, ASR = 3.5). Dissimilar to the current placement, more children were recommended to live in both parents’ care in C8 (FdvFmhMmh, ASR = 2.1) and C11 (all PPs, ASR = 2.8).

Table 6.8

Percentages of Recommended Placements for Eleven Cluster Subgroups for Two-Hundred-and-Forty-Six Children

<table>
<thead>
<tr>
<th>BLOCKS</th>
<th>CLUSTERS</th>
<th>Out of home care %</th>
<th>Kin care %</th>
<th>One parent care %</th>
<th>Both parents' care %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1: No PPs</td>
<td>C1: No probs</td>
<td>29.4</td>
<td>5.9&lt;sup&gt;b&lt;/sup&gt;</td>
<td>29.4</td>
<td>35.3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C2: Fdv</td>
<td>56.3&lt;sup&gt;a&lt;/sup&gt;</td>
<td>18.8</td>
<td>18.8</td>
<td>6.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Block 2: 1 PP</td>
<td>C3: Fsa</td>
<td>20.0</td>
<td>25.0</td>
<td>40.0</td>
<td>15.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C4: Msa</td>
<td>31.8</td>
<td>40.9</td>
<td>22.7</td>
<td>4.5</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C5: Mmh</td>
<td>39.3</td>
<td>14.3</td>
<td>35.7</td>
<td>10.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Block 3: 2 PPs</td>
<td>C6: MdvMmh</td>
<td>23.3</td>
<td>40.0</td>
<td>36.7</td>
<td>0&lt;sup&gt;b&lt;/sup&gt;</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C7: FdvFsaFmh</td>
<td>42.1</td>
<td>26.3</td>
<td>10.5</td>
<td>21.1</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C8: FdvFmhMmh</td>
<td>31.8</td>
<td>9.1&lt;sup&gt;b&lt;/sup&gt;</td>
<td>27.3</td>
<td>31.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>100.0</td>
</tr>
<tr>
<td>Block 4: Multiple PPs</td>
<td>C9: FdvFsaMdvMsa</td>
<td>4.8&lt;sup&gt;b&lt;/sup&gt;</td>
<td>47.6&lt;sup&gt;a&lt;/sup&gt;</td>
<td>28.6</td>
<td>19.0</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C10: FsaFmhMsaMmh</td>
<td>21.2</td>
<td>54.5&lt;sup&gt;a&lt;/sup&gt;</td>
<td>15.2</td>
<td>9.1</td>
<td>100.0</td>
</tr>
<tr>
<td></td>
<td>C11: All probs</td>
<td>27.8</td>
<td>11.1</td>
<td>22.2</td>
<td>38.9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>28.9</td>
<td>28.9</td>
<td>26.4</td>
<td>15.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Note: <sup>a</sup> = ASR > 2.0; <sup>b</sup> = ASR < - 2.0.

The Relationship between Current and Recommended Placements

To investigate the patterns of changes to children’s current living arrangements, the patterns of change were analysed next. Table 6.9 shows the comparisons between current and recommended placements.

As shown in Table 6.9, children were generally recommended to stay where they were currently residing. Seventy-nine percent of the children, in particular, were recommended to stay in their current placements ($k=.71$, $SE = .04$). Most differences
between current and recommended placement were towards a reunification with the biological parents, either from out of home care or from kinship care. There were only two children who were removed from their parents and six children who were moved from both parents’ to one parent’s care.

Table 6.9

*Distribution of Current and Recommended Placements for Two-Hundred-and-Forty-Six Children*

<table>
<thead>
<tr>
<th>Recommended Placement</th>
<th>Out of home care (N, %)</th>
<th>Kin Care (N, %)</th>
<th>One parent care (N, %)</th>
<th>Both parents care (N, %)</th>
<th>Total (N, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of home care</td>
<td>70</td>
<td>2</td>
<td>10</td>
<td>12</td>
<td>94</td>
</tr>
<tr>
<td></td>
<td>28.5</td>
<td>0.8</td>
<td>4.1</td>
<td>4.9</td>
<td>38.2</td>
</tr>
<tr>
<td>Kin Care</td>
<td>1</td>
<td>67</td>
<td>13</td>
<td>5</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>0.4</td>
<td>27.2</td>
<td>5.3</td>
<td>2.0</td>
<td>35.0</td>
</tr>
<tr>
<td>One parent care</td>
<td>0</td>
<td>2</td>
<td>36</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>0.0</td>
<td>0.8</td>
<td>14.6</td>
<td>0.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Both parents care</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>0.0</td>
<td>0.0</td>
<td>2.4</td>
<td>8.9</td>
<td>11.4</td>
</tr>
<tr>
<td>Total</td>
<td>71</td>
<td>71</td>
<td>65</td>
<td>39</td>
<td>246</td>
</tr>
<tr>
<td></td>
<td>28.9</td>
<td>28.9</td>
<td>26.4</td>
<td>15.9</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Recommended Change in Placement**

The 11 subgroups were then investigated in relation to change in placement and a child’s gender. Correspondence Analysis was used to examine the relative associations between the 11 cluster subgroups and 4 groups (boys and girls, change vs. no change in placement). Figure 6.5 shows that the first, horizontal dimension accounts for 58% of the variance and a second, vertical dimension accounts for 29% of the variance. Together these two dimensions account for 87% of information involved in the relative associations between the 11 cluster subgroups and four groups (boys and
girls by placement change groups), \( \chi^2 (30, 246) = 47.93, p = .02 \).

Figure 6.5 Relative associations between 11 cluster subgroups and four groups of boys/girls by placement change.

Figure 6.5 shows that children in C3 (Fsa) and C9 (FdvFsaMdvMsa) were most closely associated with recommendation of change in their current placement arrangements. Table 6.7 and Table 6.8 showed that there was a high number of reunifications to one parent care in both of these two clusters. While there were no children in C3 and C9 currently residing in one parent’s care, clinicians recommended 40% and 29% to reside with one parent, respectively. With a closer inspection of the data, only one child in C3 was recommended to the father’s care and the remaining seven children to the mother’s care. All six children in C9 were recommended to the mother’s care.

Overall, these results show that clinicians mostly recommended the children to stay in their current placements and any changes in placements were mostly towards reunification with one or both parents. Children who had mentions of father’s domestic
violence were likely to be living and recommended to stay in out of home care. Children with no mentions of parent problems were currently, and recommended to remain, in their parents’ care. Children in subgroups that had mentions of mother’s substance abuse problems were currently, and recommended to remain, in kinship care.

The only notable changes between the current and recommended care arrangements seemed to occur for children with multiple parent problems and father’s substance abuse and the change was in the direction of reunification with both parents from out of home or kinship care.

**Predictors of Recommended Placement**

To address whether parent problems, current placement and the five forms assessment issues (placement issue, protective concerns, father and mother access and child specific problems) were systematically related to clinicians’ recommendations of children’ placements, Multiple Linear Regression analyses were computed for recommended placements. As described in Chapter 4, a stepwise analysis, was used, to predict the clinicians’ recommended placement. Binary variables were dummy-coded for the analysis.

The analyses yielded six models, the last one accounting for 54% of the variance in placement recommendation. As Table 6.10 shows, current placement, mother’s domestic violence, father’s mental health problems and access arrangements were included in the final (4th) model significantly predicting the recommended placement. Figure 6.6 illustrates the individual contribution of each variable in predicting the ‘recommended placement’ variable.
Table 6.10

*Summary of Multiple Regression Analysis for Variables Associated with Recommended Placement*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
<th>Model 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>β</td>
<td>B</td>
<td>SE</td>
<td>β</td>
</tr>
<tr>
<td>Current Placement</td>
<td>.71</td>
<td>.05</td>
<td>.67**</td>
<td>.62</td>
<td>.05</td>
<td>.59**</td>
</tr>
<tr>
<td>Access for Mother</td>
<td>-.52</td>
<td>.10</td>
<td>-.25**</td>
<td>-.53</td>
<td>.10</td>
<td>-.25**</td>
</tr>
<tr>
<td>Protective Concerns</td>
<td>.34</td>
<td>.12</td>
<td>.13**</td>
<td>.30</td>
<td>.12</td>
<td>.11*</td>
</tr>
<tr>
<td>Mother's Domestic Violence</td>
<td>.24</td>
<td>.11</td>
<td>.10*</td>
<td>.26</td>
<td>.11</td>
<td>.11*</td>
</tr>
<tr>
<td>Father's Mental Health Problems</td>
<td>.23</td>
<td>.10</td>
<td>.10*</td>
<td>.28</td>
<td>.11</td>
<td>.12**</td>
</tr>
<tr>
<td>Access for Father</td>
<td></td>
<td></td>
<td></td>
<td>-.25</td>
<td>.10</td>
<td>-.11*</td>
</tr>
<tr>
<td>Adj $R^2$</td>
<td>.45</td>
<td>.50</td>
<td>.51</td>
<td>.52</td>
<td>.53</td>
<td>.54</td>
</tr>
<tr>
<td>$F$ change $R^2$</td>
<td>197.65**</td>
<td>122.70**</td>
<td>86.89**</td>
<td>67.61**</td>
<td>55.97**</td>
<td>48.64**</td>
</tr>
</tbody>
</table>

*Note:* *p < .05, **p < .01.
Figure 6.6 shows that the child’s current placement was the strongest single predictor for clinicians’ placement recommendations. Assessment issues that significantly predicted the placement recommendations were access for both parents and specific protective concerns. Children were more likely to be recommended to their biological parents’ care when there were more assessments of protective concerns but fewer assessments of access arrangements with parents, particularly with the mother. Placement recommendations were also likely to be in the parents’ care when mother’s domestic violence and father’s mental health problems were present.

Summary

The results presented in this chapter addressed Research Question 2, involving four aims surrounding whether the 11 patterns in the problems clinicians mentioned for the biological fathers and mothers of 250 children were distinctively associated with: (1)
child-related issues; (2) parent involvement in the assessments; (3) clinicians’
identification of assessment issues; (3) and recommendations about children’s
placements.

In relation to the first aim, father’s domestic violence, and parents’ substance
abuse, and the absence of parent problems were the specific patterns associated with
child-related issues. When there were no mentions of parent problems, half (9) of the
children were not living with their parents (out of home care and kinship care) and half
were with one or both parents (9). Of those who nine children in parental care, more
than half (5) also had mentions of sexual abuse. Of those nine children in out of home
placements, nearly all (8) had mentions of emotional and behavioural problems or
neglect, suggesting that they were referred to the clinic assessments for issues that were
not related to parents’ domestic violence, substance abuse or mental health problems.

Father’s domestic violence and both parents’ mental health problems were also
likely to co-occur with sexual abuse. While children with only one parent problem were
more likely to be sexually abused by their immediate family members, mostly fathers,
children with multiple parent problems were more likely to be sexually abused by
someone outside the family. Girls were more likely to be neglected when their fathers
had substance abuse problems and boys when mothers experienced substance abuse
problems. When boys were neglected, they were also more likely to have co-occurring
behavioural problems.

In relation to the second aim, children who had no mentions of parent problems
were likely to come to the assessments without their biological parents. Both parents
were more likely to attend in multiple parent problem clusters where both parents had
mental health problems. When substance abuse was the only problem, the parent with
the problem was likely to attend the assessment without the other parent. It may be that
in relation to substance abuse problems, the clinician either did not have access to or a need to assess the child’s whole family unit.

In relation to the third aim, the results showed that the assessments are likely to focus on placement issues when one parent has the problem, particularly in relation to substance abuse. In these one parent problem families, it was also less likely that the focus was access arrangements for fathers. Multiple parent problems were, however, related to access arrangement assessments for both parents, mothers in particular. Children of parents with multiple problems were also less likely to be assessed for child specific problems.

In relation to the fourth aim, clinicians recommended few changes in the ways children were placed when they received the referrals from the court. The difference between current and recommended placement showed a strong trend towards reunification with biological parents. There were more reunifications with mothers when the only parent problem was the father’s substance abuse or when parents had co-occurring domestic violence and mental health problems.

Children in the two extreme cluster subgroups, one with no mentions and one with mentions of all the parent problems, were most likely to be recommended to live with both parents. Children with violent fathers were least likely to be recommended to their parents’ care. When all six parent problems were mentioned, the only recommendations about changing placements were towards both parents’ care.

Current placement was the strongest predictor of the recommended placement, a finding that is consistent with the high agreement rate (73%) between the current and recommended placements. In addition, children were less likely to be recommended to live with their parents when the assessments were about access with fathers and mothers, the latter in particular. It is reasonable to assume that access arrangements are
more relevant for children who are not living with their biological families.

When analysed separately, the parent problems, assessment issues and current placement were associated with clinicians’ recommended placement. While child’s current placement was the strongest predictor of the recommended placement, mother’s domestic violence and father’s mental health also were positively associated with placement recommendations favouring the parents’ care. These two problems were the least prevalent problems in the clinic assessments, and it may be that clinicians do not consider them as detrimental for the parents’ ability to provide good enough care for their children. Other forms of parent problems, however, did not significantly predict placement recommendations.

Other significant predictors of the recommended placement were assessment issues identified by the clinicians. When the clinicians identified assessments issues as access arrangements for parents the placement recommendations were more likely to be in out of home care placements. When they focused on specific protective concerns, however, the placement recommendation was more likely to be to parents’ care. These analyses illustrate the factors that may be important in clinicians’ interpretations of the best interests of the child.

**Conclusion for Study 1**

The 11 cluster subgroups showed distinct patterns of clinicians’ mentions of the six parent problems. The problems of the parents, as identified in the clinicians’ reports, were complex and frequently co-occurred. On the whole, these factors included several child and parent factors, which differed across the 11 parent problem cluster subgroups. There were no cluster differences in relation to child’s gender and age. Mentions of child-related issues (emotional and behavioural problems, neglect and sexual abuse), were related to the patterns in clinicians’ mentions of parent problems. These variables
also were not systematically related to age or gender. These patterns suggest that referrals to the clinic are for reasons other than demographic variables. In addition, issues that the families were assessed for at the clinic, and recommendations of child’s placement and court protection orders, differed across the clusters.

While domestic violence in fathers was the most prevalent of all the six types of parent problems, it also seemed to be the most concerning problem in the families as it was related to child-related issues, out-home home placements and more invasive court protection orders. In these problematic families, however, fathers were more likely to attend the clinic assessment than mothers. In many cases, more than one factor plays a part. In fact, no mentions of parent problems for the C1 cluster subgroup may be related to their inaccessibility to the clinicians, given that some did not come to the clinic assessments.

It seems that domestic violence in mothers and mental health problems in fathers did not concern the clinicians to the extent that a removal of the child from their family would be warranted. On the contrary, patterns of problems involving substance abuse, particularly in relation to mothers, were associated with kinship placements, perhaps indicating that clinicians were not willing to cut the child’s ties from biological family units and to allow mothers to recover from their personal issues before planning a family reunification. Alternatively, there may be other factors related to family dynamics in families where substance abuse is an issue that allow the child to reside in relatives’ care.

The variations of co-occurring problems are also likely to contribute to interpretations of the wide array of other family information obtained from the assessments. The details clinicians mentioned in their assessments not only form
patterns within the six parent problems but are also associated with other factors the clinicians used as a basis for making recommendations to the court.

The main findings of Study 1 illustrate that the parent problems do make a difference in clinicians’ recommendations for children’s placements. The patterns in the parents’ problems also relate to child-related issues and specific assessment issues identified by the clinicians. The point of the recommendations, then, is to inform the court in matters where they require assistance about what is in the child’s best interests. Study 2 focuses on relating the clinicians’ recommendations to court decisions: decisions about court orders and about placements. Court decisions in Study 2 are made in relation to groups of children who share the same familial environment. Because of the distribution of fathers and mothers across the families is complex, the focus of the analyses in Study 2 is on families where children had the same father and mothers. For these 138 families the analyses concentrate on the depth of the clinicians’ attention to the parent problems, and then on the relationships between clinicians’ recommendations and court decisions.
Chapter 7

STUDY 2: RELATIONSHIP BETWEEN CLINICIANS’ RECOMMENDATIONS AND COURT FINAL DECISIONS

This chapter addresses Research Question 3 on 138 families that were referred to the Children’s Court Clinic of Victoria for psychosocial assessments. Building on the findings from Study 1 of 250 children and the patterns in six forms of parent problem, Study 2 involved specifying the level of attention clinicians gave to the problems mentioned for parents in the same families. The salience measure was generated to identify the level of clinicians’ concern with the current state of each problem. The specific aims for Research Question 3 were to:

(1) Identify any systematic differences in the salience score measures of attention and concern for three types of parent problems for fathers and mothers.

(2) Examine the relationship between clinic recommendations and court decisions about court protection orders and placements.

(3) Analyse whether assessment issues or the salience of parent problems were associated with the clinic and court outcomes concerning protection orders and children’s placements.

There are four reasons for shifting the focus from the individual child to the family: (1) the assessments and recommendations were made to the court for the families (in only two reports were the recommendations about orders and placements different for the individual children and these were excluded from the analyses); (2) most cases involved only one father and mother, usually the biological parents. In 10 families that involved two fathers it was clear who the primary father in the functional family unit was and that father was identified as the father for the formal analyses; (3) the matters heard before the court were mostly heard in relation to family units and
court final decisions were mostly consistent within these families; and (4) empirically, by focusing on family units and one father and mother, it was possible to examine a uniform set of parents when making comparisons between clinicians’ recommendations and court decisions.

This chapter concentrates on comparing recommendations made by clinicians at the children’s court clinic and the decisions made at the children’s court. Of particular interest was how clinicians’ recommendations of court protection orders and children’s placements were associated with the salience of the parent problems (DV, SA, and MH for fathers and mothers) clinicians mentioned in the reports to the court.

The analyses involved a finer coding scheme for the parent problems that reflected the level of attention the clinicians gave to each of the 3 types of parent problems mentioned in the 138 reports. Additional data were derived from the children’s court Lex, regarding court’s final decisions on protection orders and children’s placements after the clinic assessment.

CODIFICATIONS OF PARENT PROBLEMS, COURT PROTECTION ORDERS, AND CHILDREN’S PLACEMENT

The Salience of Parent Problems Assigned by Clinicians

All mentions for the six forms of parent problem (domestic violence; substance abuse; mental health problems for fathers and mothers) in the 138 reports were coded into levels of salience. This involved making a judgment about how much attention the clinicians placed on each parent problem (i.e., how salient, concerning, or prominent the problem was in the clinic reports). For each report, the highest level of salience was recorded. Coding involved the following coding system: 0 = not mentioned; 1 = low level of salience – not of great concern now, could have been a concern in the past; 2 = medium level of salience in present time; and 3 = serious, high level of salience in
Coding was achieved for every mention of each problem for fathers and mothers by giving each report a combination of six codings. The coding represented the highest level of salience in the report for each of the six parent problems. A detailed coding scheme for the levels with examples is shown in Appendix B. A second coder independently coded all mentions of the 6 parent problems in 45 (33%) reports. There was an 87% agreement rate between the two coders. The combined interjudge-reliability for the three levels of six parent problems in the 45 reports was sufficiently high ($k = .78, SE = .10$). Disagreements were resolved by discussion. Cohen’s Kappa’s for each of the six parent problems are shown in detail in Appendix B.

**Coding Court Protection Orders and Children’s Placement**

The current court protection order for the child at the time of the assessment was mentioned in clinic assessment report. It was also cross-checked against the court Lex system. A clinician’s recommendation concerning a court protection order was part of the dispositional summary and recommendations. Both current and recommended protection orders were coded on a seven-point scale ranging from 0 to 6 to reflect the intrusiveness of the order following a scheme devised by Lawrence and colleagues (Lawrence et al., 2010; Lawrence et al., 2008). Protection orders are mainly used in analyses for Study 2.

Five forms of order were included in the analyses. They were coded as a scale moving towards intrusiveness, following a scheme devised by Lawrence and colleagues (Lawrence et al., 2010; Lawrence et al., 2008). These forms were identified, presented to the court and accepted as reflecting court procedures (Suomi & Lawrence, 2011). The specific codings for court orders are shown in Table 7.1. The five forms of court order were:
(1) Current court order that the children were under at the time of the assessment called ‘current court order’.

(2) Orders recommended by the clinicians in the report – called ‘clinicians’ recommended court order’.

(3) The first order on file at the court after the date of the clinic’s assessment called ‘first court order after assessment’. It represents the next order recorded in Lex immediately after the date of the clinic assessment. This order was usually an interim order. There is no consistent recording of the date of the actual presentation of the clinic report on Lex.

(4) The first substantive final order made by the court after the clinicians’ report was presented to the court – called “first substantive court order”. This order was the next order on file in Lex. The first substantive final order was usually preceded by an interim order, signifying that the hearing of the protection matter was pending and a substantive court order had not yet been made.

(5) The “last court order on file” as recorded in Lex in June 2011.

Table 7.1
Codings for Current, Recommended and Court Protection Orders

<table>
<thead>
<tr>
<th>Court Protection Order</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim order (no final order yet recommended or made)</td>
<td>0</td>
</tr>
<tr>
<td>Struck out, Withdrawn, Revoked</td>
<td>1</td>
</tr>
<tr>
<td>Parents Undertaking to the Court</td>
<td>2</td>
</tr>
<tr>
<td>Supervision</td>
<td>3</td>
</tr>
<tr>
<td>Custody to the Secretary</td>
<td>4</td>
</tr>
<tr>
<td>Guardianship to the Secretary</td>
<td>5</td>
</tr>
<tr>
<td>Permanent Care</td>
<td>6</td>
</tr>
</tbody>
</table>
There were also three forms of the placement of the child. One of the main decision-making principles guiding protective decisions at children’s courts is the stability of children’s placements and family reunification where appropriate (CYFA 2005, s.10). Therefore, it was important to compare clinicians’ recommendations and court decisions about children’s current placements. Table 7.2 shows the codings for placements, including a scale towards reunification with both parents. They were coded for three decisions:

1. ‘Current placement’ that the child was on at the time of the assessment
2. Children’s placement that was recommended by the clinicians in the report – called ‘recommended placement’.
3. The first placement on file in the court Lex system after the date of the clinic’s assessment – called ‘court-ordered placement’. Similar to the court protection orders, there is no consistent recording of the date of the actual presentation of the clinic report on Lex.

Table 7.2
Codings for Children’s Current and Recommended Placement

<table>
<thead>
<tr>
<th>Placement</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of home care (foster or institutional)</td>
<td>0</td>
</tr>
<tr>
<td>Kinship care</td>
<td>1</td>
</tr>
<tr>
<td>Placement with one parent only</td>
<td>2</td>
</tr>
<tr>
<td>Placement with both parents (whether living together or not)</td>
<td>3</td>
</tr>
</tbody>
</table>

STATISTICAL ANALYSES FOR STUDY 2

The differences in the level of salience between the three types of parent problem for fathers and mothers in the 138 reports were analysed with a double Repeated Measures Analysis of Variance (3 problem types, 2 parents) for the sample.
To investigate whether the salience scores between the types and the parents were related to agreements between court and clinic about court orders and children’s placements, categorical ‘agreement’ variable was entered as a between-subjects factor for the double Repeated Measures Analysis of Variance.

Another set of Repeated Measures Analysis of Variance was used to compare the average scores between different orders and placements at particular occasions in the families’ protection history about court orders and children’s placements.

Chi-square analyses were used to investigate the associations between the clinic and court outcomes. Cohen’s Kappa was computed to report the rate and patterns of agreement for the clinic and the court. Finally, Multiple Linear Regression Analysis using stepwise method was used to test which variables would best predict, or associate with, clinicians’ recommendations and court decisions about protection orders and children’s placements. The analyses also showed whether clinic and court outcomes were related to the salience scores of the three forms of parent problems developed on the basis of three types of parent problems.

**SALIENCE OF SIX FORMS OF PARENT PROBLEMS**

Given that Study 1 revealed different prevalence rates and distinct patterns in the problems of the parents, it was of interest to explore whether the salience and levels of clinicians’ attention to parent problems were also different for three types of parent problems (DV, SA, MH), for fathers and mothers. Differences in the level of salience between the three types of parent problem for fathers and mothers in the 138 reports were analysed with a double Repeated Measures Analysis of Variance (3 problem types, 2 parents) for the sample.

The mean salience scores for parent and type are shown in Table 7.3. There was a significant interaction in the salience scores for the problem type by parent, $F(2, 274)$
= 44.72, \( p = .00, \eta^2 = .32 \), and a significant main effect for parent, \( F(1, 137) = 4.49, p = .04, \eta^2 = .12 \), but not for the type of problem \( F(1, 137) = 2.52, p = .08, \eta^2 = .03 \).

Mauchly’s Test for Sphericity was not significant, \( W = .98, \chi^2(2) = 2.25, p = .32 \). The interaction is illustrated in Figure 7.1.

These results are reported with caution, due to large standard deviations and positive skewness. To deal with problems of normality, prior to running the formal analyses, all six parent problem variables were transformed using natural Log transformation (LN), given that Fsa, Fmh, Mdv variables showed positive skewness (0.79, 1.66, and 1.5, respectively). There were many low level mentions for these three parent problems. The tests showed no interference from outliers or kurtosis for the 6 variables, and analyses did not yield significantly different results for the transformed versus untransformed variables and so the results presented here are based on the untransformed variables.

Table 7.3

<table>
<thead>
<tr>
<th>Parent</th>
<th>Type of Problem</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Domestic Violence</td>
<td>1.15</td>
<td>1.22</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse</td>
<td>0.97</td>
<td>1.21</td>
</tr>
<tr>
<td></td>
<td>Mental Health Problems</td>
<td>0.54</td>
<td>1.07</td>
</tr>
<tr>
<td>Mother</td>
<td>Domestic Violence</td>
<td>0.60</td>
<td>1.08</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse</td>
<td>1.20</td>
<td>1.32</td>
</tr>
<tr>
<td></td>
<td>Mental Health Problems</td>
<td>1.51</td>
<td>1.37</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>1.00</td>
<td>1.22</td>
</tr>
</tbody>
</table>

As Figure 7.1 shows, the highest salience score was for mother’s mental health problems, followed by father’s domestic violence. Mean salience scores for substance
abuse for fathers and mothers were similar, although somewhat higher for mothers. The lowest salience scores were for father’s mental health problems and mother’s domestic violence.

**Figure 7.1** The average scores of domestic violence, substance abuse and mental health problems for fathers and mothers in 138 families assessed at the clinic.

There was a wide variability of salience scores for the six parent problems, as shown by large standard deviations in Table 7.3. Figure 7.2 illustrates the wide distributions of the scores for each of the parent problems. In relation to all six forms of parent problem, the highest frequency was for ‘not mentioned’ (illustrated by ‘0’), with the exception of mother’s mental health problems, which had equally many (40%) mentions of ‘current and serious concern’ (illustrated by ‘3’). When the problem is mentioned, however, there were more current and concerning mentions (illustrated by 3) in comparison to lower level mentions (illustrated by 1 and 2).
As shown in Figure 7.2, mother’s mental health problems, being the most prevalent problem in the reports, had more current and concerning mentions in comparison to other parent problems. Father’s mental health problems and mother’s domestic violence had fewer mentions overall. These analyses suggested that salience scores could be used in other analyses with caution. First, the patterns of decisions are reported.
THE RELATIONSHIP BETWEEN RECOMMENDATIONS AND COURT DECISIONS ABOUT PROTECTION ORDERS

The clinicians’ recommendations and court decisions on protection orders and placements are examined next by comparing the levels of orders and placements at different time points: (1) current court decision; (2) clinician’s recommendation; and (3) court decision subsequent to the date of the clinic report.

Clinicians’ recommendations for court protection orders differed from the current court order and orders subsequently handed down in court. Repeated Measures Analysis of Variance was used to examine whether the current court order, clinicians’ recommended court order, and three subsequent court protection orders were similar or different for 127 families for which there were records of all five orders. As noted, these five kinds of order were: the current court order, the clinicians’ recommended court order, the first court order after assessment, the first substantive court order and the last court order on file.

There were large standard deviations for the five kinds of order, thus, appropriate transformations were used for the five protection order variables. The results reported here, however, were based on the untransformed variables, given that both sets of variables resulted in similar effects. Table 7.4 shows that the mean order scores were significantly different across the five kinds of order, $F(1, 126) = 59.06, p = .00$, $\eta^2 = .32$. Overall, the trends were towards more intrusive orders across court orders over time, as shown in Figure 7.3.
Table 7.4

*Mean Order Scores for Five Kinds of Protection Order*

<table>
<thead>
<tr>
<th>Order</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician’s recommended court order</td>
<td>2.59</td>
<td>1.72</td>
</tr>
<tr>
<td>Current court order</td>
<td>1.11</td>
<td>1.79</td>
</tr>
<tr>
<td>First court order after the assessment</td>
<td>1.17</td>
<td>1.82</td>
</tr>
<tr>
<td>First substantive court order</td>
<td>3.14</td>
<td>1.36</td>
</tr>
<tr>
<td>Last court order on file</td>
<td>3.41</td>
<td>1.50</td>
</tr>
</tbody>
</table>

*Note:* All comparisons with recommended court order were statistically significant at $p = .00$ using transformed (LN) and actual Mean Scores, by using simple contrasts.

As Table 7.4 shows, there were two kinds of order that were less intrusive than the orders recommended by the clinicians. These were the order currently before the court at the time the clinicians made their assessments and the first court orders on file in Lex after the date of the assessments. The mean for the first substantive court orders and last court orders on file were considerably higher than the clinicians’ recommended court orders. The means for the first substantive court order and the last court orders did not differ greatly, although there was a slight trend towards a higher (more intrusive) order score in the last order.

The mean order score for the clinic’s recommendation was significantly higher than the mean order score for the current court order, $F(1, 126) = 59.06, p = .00, \eta^2 = .32$, and the mean order score for the next order after the assessment, $F(1, 126) = 50.79, p = .00, \eta^2 = .29$. The next order after the assessment was most frequently an Interim order. In contrast, the mean order score for the clinic’s recommendation was significantly lower than the mean order score for the first substantive court order after assessment, $F(1, 126) = 10.36, p = .01, \eta^2 = .08$, and the last order on file, $F(1, 126) = 23.70, p = .01, \eta^2 = .16$. 
Figure 7.3 Mean Order Score across five kinds of order.

Figure 7.3 shows that the orders made were likely to be more intrusive the longer the matter was before the court. The last order on file correlated moderately well with the number of months to its date from the date of the assessment ($r = .48, p = .00$).

Some of these mean scores had large variations, as indicated by the large standard deviations in Table 7.3, so it was important to look at the patterns of individual forms of order (e.g., supervision, custody). Therefore, the percentages of individual types of orders within these comparisons were investigated. The patterns of order are shown for each kind of order for interim, struck out, undertaking, supervision, custody, guardianship, and permanent care orders in Figure 7.4. The numbers involved are slightly different, because the clinicians did not recommend orders for all cases.
Figure 7.4 Five patterns of seven kinds of protection order.

Figure 7.4 shows the frequency of protection orders, at the current, recommended, first order and first substantive order and the last court order on file. The figure illustrates that subsequent court orders involved more intrusive orders.
Factors associated with Court Protection Orders

To address whether preceding protection orders, assessment issues (father and mother access) and the salience of the six forms of parent problem were systematically related to the three types of protection order (recommended court order, first court order after the assessment and last court order on file), three stepwise multiple regressions were computed separately to predict: (1) clinicians’ recommended court orders; (2) first substantive court orders; and (3) last order on file.

Clinician’s Recommended Court Order

The first (and final) model included only current court order ($\beta = .24, t(126) = 2.72, p < .01$) which significantly explained a small (6%) proportion of variance in the clinicians’ recommendation of protection order, $R^2 = .06, F(1, 126) = 7.39, p < .01$.

First Substantive Court Order

Figure 7.5 and Table 7.5 show the summary of the multiple regressions. The analyses yielded four models, the last one accounting for 26% of the variance in the first substantive court order. Current court order, $\beta = .35, t(126) = 4.35, p < .00$, mother’s mental health problems, $\beta = .21, t(126) = 2.64, p < .01$, access arrangements for mother, $\beta = .19, t(126) = 2.23, p < .02$, and father’s substance abuse, $\beta = .16, t(126) = 2.11, p < .4$, were included in the final model, $R^2 = .26, F(1, 126) = 11.92, p < .00$.

*Note:* all regression coefficients, $p < .05$ level

*Figure 7.5* Standardised Beta weights for predictors of first substantive court order for 127 families.
Table 7.5

*Summary of Multiple Regression Analysis for Variables Predicting First Substantive Court Order*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th></th>
<th>Model 2</th>
<th></th>
<th></th>
<th>Model 3</th>
<th></th>
<th>Model 4</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>β</td>
<td>B</td>
<td>SE</td>
<td>β</td>
<td>B</td>
<td>SE</td>
<td>β</td>
<td>B</td>
<td>SE</td>
</tr>
<tr>
<td>Current court order</td>
<td>.29</td>
<td>.06</td>
<td>.39**</td>
<td>.30</td>
<td>.06</td>
<td>.39**</td>
<td>.26</td>
<td>.06</td>
<td>.34**</td>
<td>.26</td>
<td>.06</td>
</tr>
<tr>
<td>Salience of Mother MH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.26</td>
<td>.08</td>
</tr>
<tr>
<td>Access for Mother</td>
<td>.21</td>
<td>.08</td>
<td>.21**</td>
<td>.21</td>
<td>.08</td>
<td>.21**</td>
<td>.21</td>
<td>.08</td>
<td>.21**</td>
<td>.51</td>
<td>.22</td>
</tr>
<tr>
<td>Salience of Father SA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.18</td>
<td>.09</td>
<td>.16*</td>
</tr>
<tr>
<td>Adj $R^2$</td>
<td>.14</td>
<td></td>
<td></td>
<td>.21</td>
<td></td>
<td></td>
<td>.24</td>
<td></td>
<td>.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$F$ change $R^2$</td>
<td>21.98**</td>
<td></td>
<td></td>
<td>11.20**</td>
<td></td>
<td></td>
<td>5.79*</td>
<td></td>
<td>4.43*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05. **p < .01.

**Last Court Order on File**

The analyses yielded three models, the last one accounting for 21% of the variance in the last court order on file, $R^2 = .21$, $F(1, 126) = 11.97$, $p < .00$. Table 7.6 shows that the first substantive court order, $\beta = .60$, $t(126) = 3.45$, $p < .00$, and clinicians’ recommended court order, $\beta = .17$, $t(126) = 2.57$, $p < .01$, together accounted for a significant proportion of the scores on the last court order. Figure 7.6 shows the single contribution of three variables on the last court order on file.
Table 7.6
Summary of Multiple Regression Analysis for Variables Predicting last Court Order on File

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>β</td>
</tr>
<tr>
<td>Current court order</td>
<td>0.32</td>
<td>0.07</td>
<td>.38**</td>
</tr>
<tr>
<td>Recomm. order</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access for Mother</td>
<td>0.51</td>
<td>0.25</td>
<td>0.17*</td>
</tr>
<tr>
<td>Adj R²</td>
<td>0.14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F change R²</td>
<td>21.52**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05. **p < .01.

Figure 7.6 Standardised Beta weights for predictors of last court order for 127 families.

In summary, current court order was significantly associated with all three types of subsequent order: clinicians’ recommended protection orders, first substantive court order after the assessment and the last court order on file by June 2011.

While the clinicians’ recommended court order was significantly associated with the current court order, the first substantive court order was also reliably related to the salience of mother’s mental health problems and father’s substance abuse and the assessment issue of access for the mother. First substantive court orders were more intrusive in families where assessments focused on access arrangements for mothers,
and associated with higher levels of salience for mother’s mental health problems and father’s substance abuse.

Clinicians’ recommended court orders were not significantly associated with the first substantive court order after the assessment. They were, together with current court order and the assessment issue of access for mother, associated with the last court order on file. For families where clinicians’ identification of an assessment issue concerned access arrangements with the mother, both first substantive court order and last court order on file were more intrusive.

**Clinic and Court Agreement on Protection Orders**

The agreement between clinic recommendations and court decisions about protection orders was examined for 127 clinic reports, followed by agreement for 134 placement decisions. Table 7.7 shows the comparison between orders recommended by clinicians and orders made by the court in the first substantive court order after the assessment.

As shown in Table 7.7, most agreements between clinic and the court were on Custody Orders (35%), followed by Supervision Orders (14%) and Interim orders (6%). The comparisons between clinic and court protection orders were categorised into three groups, where: (1) the court and clinic agreed on the orders (57%); (2) the first substantive court order was more intrusive than the clinicians’ recommended orders (28%) and; (3) the first substantive court order was less intrusive than the clinic recommended court order (15%).
Table 7.7
Comparison between Clinicians’ Recommendations and First Substantive Protection Orders for Hundred-And-Twenty-Seven Court Matters

<table>
<thead>
<tr>
<th>Rec. Order</th>
<th>First substantive court order</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>INT %</td>
<td>STR %</td>
</tr>
<tr>
<td>Interim</td>
<td>8</td>
<td>0.0</td>
</tr>
<tr>
<td>(INT)</td>
<td>6.3*</td>
<td></td>
</tr>
<tr>
<td>Struck out</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>(STR)</td>
<td>0.0</td>
<td>0.8*</td>
</tr>
<tr>
<td>Supervision</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>(SPO)</td>
<td>3.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Custody</td>
<td>3</td>
<td>0.0</td>
</tr>
<tr>
<td>(CSO)</td>
<td>2.4</td>
<td>5.5</td>
</tr>
<tr>
<td>Guardianship</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>(GSO)</td>
<td>.8</td>
<td>.8</td>
</tr>
<tr>
<td>Total %</td>
<td>16</td>
<td>3</td>
</tr>
</tbody>
</table>

Note: * = ASR > 2.0

Clinic and Court Outcomes for Protection Orders in Relation to Parent Problems

The orders made by the clinicians and the court were next compared in relation to the salience of the parent problems, that is, whether the levels of salience for three types of problems for fathers and mothers were related to agreements and disagreements between clinicians’ recommendations and court decisions about protection orders. These associations were expected to reflect potential differences in the psychological and legal understanding about the level of intervention the families require in relation to parent problems. As argued in Chapter 3, psychological and legal criteria cannot be expected always to co-ordinate. Judges and magistrates take different and additional
material into account when making orders. Therefore it was useful to add the following analyses on agreement and disagreement.

A double Repeated Measures Analysis of Variance with within-subjects factor of problem types (3) by parents (2) was used to explore the differences in the salience of parent problems across three agreement groups about court orders (court more intrusive, agreement, court less intrusive), which was entered as a between-subjects factor.

Table 7.8 shows the salience scores for father and mother problems across the three agreement groups and the interaction for parent by agreement groups is shown in Figure 7.7. There was a significant interaction for parent by agreement group, $F(2, 248) = 4.31, p = .02, \eta^2 = .07$, but no interaction for type by agreement group, $F(4, 248) = 1.17, p = .33, \eta^2 = .02$, no effect for type, $F(2, 248) = .31, p = .73, \eta^2 = .01$, nor for parent, $F(1, 248)=.07, p = .78, \eta^2 = .01$, and no three-way interaction, $F(4, 248) = .26, p = .91, \eta^2 = .01$. Mauchly’s test for sphericity was not significant, $W = .96, \chi^2(2) = 5.15, p = .07$.

Table 7.8

<table>
<thead>
<tr>
<th>Comparison group</th>
<th>Parent</th>
<th>Mean salience score</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court order more Intrusive than clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>1.15</td>
<td>.15</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>1.20</td>
<td>.14</td>
</tr>
<tr>
<td>Agreement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>.81</td>
<td>.11</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>1.26</td>
<td>.10</td>
</tr>
<tr>
<td>Court order less intrusive than clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>1.02</td>
<td>.21</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>.61</td>
<td>.19</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>.99</td>
<td>.16</td>
</tr>
<tr>
<td></td>
<td>Mother</td>
<td>1.02</td>
<td>.15</td>
</tr>
</tbody>
</table>
Figure 7.7 Patterns in mean salience scores for fathers and mothers across three agreement groups on protection orders.

As shown in Figure 7.7, the level of salience for both father and mother problems was high when court orders were more intrusive than clinic recommendations for both fathers and mothers. The level of father problems was lower than for mothers when the court agreed with the clinic. When the level of mother problems was lower than the level of father problems, however, court decisions were less intrusive than the clinic recommendations.

In summary, these analyses showed that court orders grew progressively more intrusive over time from the first court order after the to the last court order on file. The clinicians’ recommendations of court orders were less intrusive than court orders, with the exception of the first court protection order made immediately after the assessment (usually an interim order). While court orders were more intrusive than clinic orders, they did agree with clinic recommendations on the type of orders for 57% of the families. In families for which the clinic and the court agreed on the protection order,
the level of mother problems was higher than the level of father problems. When the court protection order was less intrusive than the clinic recommendation, however, the level of father problems was higher.

THE RELATIONSHIPS BETWEEN CLINIC RECOMMENDATIONS AND COURT DECISIONS ABOUT CHILDREN’S PLACEMENT

Together with court protection orders, the clinic reports and court record consistently include a statement about a child’s placement. The focus of the next analysis was whether there was a significant difference between the three kinds of placements for children: (1) current placement; (2) clinicians’ recommendations about placement; and (3) court ordered placement after the assessment.

The mean placement scores across the three kinds of placement are shown in Table 7.9. Repeated Measures Analysis of Variance showed a significant difference between the children’s current placement score, the recommended placement score and court placement score, $F(2, 132) = 10.39, p = .00, \eta^2 = .43$.

Table 7.9  
Mean Placement Scores for Three Kinds of Placements

<table>
<thead>
<tr>
<th>Placement recommended by the clinic</th>
<th>1.25</th>
<th>1.02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current placement</td>
<td>0.96</td>
<td>0.96</td>
</tr>
<tr>
<td>Placement ordered by the court</td>
<td>1.02</td>
<td>0.93</td>
</tr>
</tbody>
</table>

Note: All comparisons with recommended placement, significant at $p = .00$, for both transformed and untransformed variables

Mauchly’s Test of sphericity was significant, $W = .96, \chi^2(2) = 5.96, p = .05$, and the corresponding corrective coefficient was Greenhouse-Geisser $\varepsilon = .86$. Given the large standard deviations, the 3 placement variables were transformed using appropriate Log transformations. The results from both sets of variables yielded equivalent results, thus, the reported findings are based on the untransformed variables.
Two simple contrasts showed that the mean placement score for the clinic recommendation was significantly higher than the mean score for the current placement when the case was referred to the clinic for assessment, $F(1, 132) = 18.97, p = .00, \eta^2 = .09$, and when the placement was ordered by the court, $F(1, 132) = 8.64, p = .01, \eta^2 = .06$. These results indicate that clinicians were more likely to recommend children to live with their parents in comparison to current placements and the placements the court ordered after the clinic assessment.

Factors associated with Children’s Placement

Stepwise Multiple Linear Regressions were used to determine whether current and recommended placements were related to: assessment issues about father and mother access, the child’s current placement and the salience of the six forms of parent problem. Two stepwise multiple regression analyses were computed separately for: (1) clinicians’ recommendations for placements; and (2) court decisions about placements.

Clinicians’ Recommendations about Placement

As shown in Table 7.10, the analyses yielded three models, the final accounting for 53% of the variance in the recommended placement, $R^2 = .53, F(3, 134) = 51.32, p = .00$. Current placement, $\beta = .63, t(134) = 10.45, p = .00$, access arrangements for mother, $b = -.26, t(134) = -4.10, p = .00$, and mother’s mental health, $\beta = .18, t(134) = 2.87, p = .01$, were significantly associated with the recommended placement.
Table 7.10  
**Summary of Multiple Regression Analysis for Variables Predicting Recommended Placement**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>B</td>
</tr>
<tr>
<td>Current Placement</td>
<td>.72</td>
<td>.07</td>
<td>.67</td>
</tr>
<tr>
<td>Access for Mother</td>
<td>-.42</td>
<td>.12</td>
<td>-.21**</td>
</tr>
<tr>
<td>Salience of Mother’s MH</td>
<td></td>
<td></td>
<td>.13</td>
</tr>
<tr>
<td>Adj R²</td>
<td>.47</td>
<td></td>
<td>.50</td>
</tr>
<tr>
<td>F change R²</td>
<td>117.40**</td>
<td></td>
<td>11.50**</td>
</tr>
</tbody>
</table>

Note: *p < .05. **p < .01.

As shown in Table 7.10, the first model only included current placement and the second model both current placement and access for mother. The final model showed that current placement was the strongest predictor of the placement recommendations, followed by access arrangements for mother and finally, the salience of mother’s mental health problems. The recommended placement was more likely to be with biological parents when there were fewer assessments about access for mother and higher levels of salience for mother’s mental health problems. Figure 7.8 shows the single contributors that were significant in predicting clinicians’ recommended placement.

![Figure 7.8 Standardised Beta weights for three significant predictors of clinicians’ recommendations of placements for 134 families.](image-url)
**Court ordered placement.** Only current and recommended placements were significantly associated with the court-ordered placement. The first model showed that current placement alone accounted for 54% of the variance in court-ordered placement. Adding clinicians’ recommended placement in the final model (model 2) significantly changed the proportion of variance (3%) explained in the court placement. As shown in Table 7.11, current placement, $\beta = .57$, $t(134) = 8.75$, $p = .00$, and recommended placement, $\beta = .17$, $t(134) = 3.16$, $p = .01$, together explained 57% of the variance in the court placement in the final model. The single contributions of current and recommended placements are shown in Figure 7.9.

Table 7.11

*Summary of Multiple Regression Analysis for Variables Predicting First Substantive Court Order*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$B$</td>
<td>$SE$</td>
<td>$B$</td>
<td>$SE$</td>
</tr>
<tr>
<td>Current Placement</td>
<td>0.72</td>
<td>0.06</td>
<td>0.74**</td>
<td>0.55</td>
</tr>
<tr>
<td>Recommended Placement</td>
<td></td>
<td></td>
<td></td>
<td>0.23</td>
</tr>
<tr>
<td>Adj $R^2$</td>
<td>0.54</td>
<td></td>
<td></td>
<td>0.57</td>
</tr>
<tr>
<td>$F$ change $R^2$</td>
<td>154.32**</td>
<td></td>
<td></td>
<td>87.99**</td>
</tr>
</tbody>
</table>

*Note:* *$p < .05$. **$p < .01.$

*Figure 7.9* Standardised Beta weights for two significant predictors of court-ordered placements for 134 families.
As shown in Figure 7.9, court-ordered placement was only significantly associated with current and recommended placement, the current placement being a stronger predictor than the clinic recommendation.

In sum, clinicians’ recommendations about the children’s placement were significantly associated with the current placement, assessments of access for mother, and mother’s mental health problems. Higher scores in the current placement were related to higher scores in the recommended placements, reflecting the clinicians’ tendency not to remove the child from their current placement. When the assessment was about access for mother, the recommended placement was less likely to be with the parents. The recommended placements were more likely to be with the parents when there were higher salience scores for mother’s mental health problems. Court-ordered placements were only related to current and recommended placements, particularly to current placement.

**Clinic and Court Agreement on Children’s Placements**

Table 7.12 shows the crosstabulation of clinic and court placements. The court agreed with 73% ($n = 98$) of the clinic recommendations about children’s placements ($\kappa = .63, \ SD = .05$). Agreements were mostly in relation to out of home placements (26%) and kinship care (27%). There was less agreement about one parent’s care (17%) and about both parents’ care (3%).

To illustrate the patterns in the comparison between clinic and court placements, the placement decisions were categorised into three groups for further analyses. The first group involved all the agreements between the clinic and the court (73%, $n = 98$) and the second group involved matters where a court placement decision was towards the child’s family, in comparison to clinicians’ recommended placement (8%, $n = 10$). In the third group, the court ordered placements were away from the child’s family.
towards out of home care (19%, \( n = 25 \)), in comparison with clinic recommendations.

Table 7.12

Recommended Placements and Placements Ordered by the Court in Hundred-and-Thirty-Three Protection Matters

<table>
<thead>
<tr>
<th>Court Placement</th>
<th>Out of home ((N, %))</th>
<th>Kinship ((N, %))</th>
<th>One parent ((N, %))</th>
<th>Both parents ((N, %))</th>
<th>Total ((N, %))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-home care</td>
<td>34 25.6(^a)</td>
<td>2 1.5</td>
<td>0 .0</td>
<td>1 .8</td>
<td>37 27.8</td>
</tr>
<tr>
<td>Kin care</td>
<td>2 1.5</td>
<td>37 27.8(^a)</td>
<td>3 2.3</td>
<td>0 .0</td>
<td>42 31.6</td>
</tr>
<tr>
<td>One parent</td>
<td>6 4.5</td>
<td>5 3.8</td>
<td>23 17.3(^a)</td>
<td>4 3.0</td>
<td>38 28.6</td>
</tr>
<tr>
<td>Both parents</td>
<td>4 3.0</td>
<td>1 .8</td>
<td>7 5.3</td>
<td>4 3.0(^a)</td>
<td>16 12.0</td>
</tr>
<tr>
<td>Total</td>
<td>46 34.6</td>
<td>45 33.8</td>
<td>33 24.8</td>
<td>9 6.8</td>
<td>133 100.0</td>
</tr>
</tbody>
</table>

Note: \(^a\) = ASR > 2.0

Clinic and Court Agreement about Placements in Relation to Parent Problems

A double Repeated Measures Analysis of Variance for three types of problem (DV, SA, MH) by two parents (father, mother) was computed using the three placement agreement groups (court towards both parents, agreement, court away from both parents) as a between-subjects factor, to examine whether the salience of the three types of parent problems (type) for fathers and mothers (parent) were different across the three clinic and court agreement groups about children’s placements.

Figure 7.10 shows the trends for the salience of father and mother problems across three agreement groups. Although the analysis showed no significant main
effects or interactions, this analysis was included for consistency and comparison with Figure 7.7 for orders, where there was a significant interaction.

The analysis showed that there was no significant interaction for type by agreement, $F(4, 260)=1.72, p = .15, \eta^2 = .01$, or parent by agreement, $F(2, 260)=2.24, p = .11, \eta^2 = .02$, and no three-way interaction, $F(4, 260)=.93, p = .45, \eta^2 = .01$. There were no main effects for type, $F(2, 260)=.28, p = .76, \eta^2 = .01$, or parent, $F(2, 260)=.02, p = .89, \eta^2 = .00$.

![Figure 7.10 Trends in patterns of mean salience scores for fathers and mothers across three agreement groups on children’s placement (ns., $p = .15$).](image)

As shown in Figure 7.10, while the differences in the salience scores across the court and clinic agreements about placement were not significant, the court seemed to order children towards parents care when fathers had higher level of problems than mothers.

**Summary**

The results reported in this chapter addressed the three aims of the *Research Question 3*, concerning: (1) the level of attention clinicians gave to the three types of problems for mothers and fathers; (2) the court agreements with the clinicians’
recommendations about court protection orders and children’s placement; and (3), the analyses showed whether the assessment issues and the salience of parent problems were related to the recommendations and the actual court orders and placement decisions for children.

In relation to the first aim, clinicians’ attention, recorded as the salience scores for parent problems, were different between the types of problems and between fathers and mothers. Overall, the level of salience for mother problems was higher in comparison to fathers. The salience of father’s domestic violence and mother’s mental health problems were highest and the levels of father’s mental health problems and mother’s domestic violence the lowest. The salience of both parents’ substance abuse in clinic assessment reports was alike, although slightly lower for fathers.

In relation to the second aim, the court agreed on 57% of the clinic recommendations about protection orders. The court also agreed on 73% clinic recommendations about children’s placements. The salience of parent problems was related to clinic and court agreements about protection orders. They were not, however, significantly related to agreements about placements. In matters where the court agreed with the clinic recommendation, the salience of mother’s problems, overall, was higher. In matters where the court protection was more intrusive than clinic recommendations, however, the father problems were significantly higher. Similar, although not significant, trend was shown in relation to clinic and court agreements and disagreements about placements: when the court disagreed with the clinic about placements and ordered children towards parents’ care, the salience of father problems was higher than the salience of mother problems. In other families the salience of the mother’s problems was higher.
In relation to the third aim, mainly mother-related issues were associated with protection orders and placements. Court orders were more intrusive when the salience of mother’s mental health problems was high and the assessment issues were about access with the mother. High salience attributed to father’s substance abuse was also related to more intrusive orders. Similarly, clinicians’ recommended placements were related to the salience of mother’s mental health problems and access for the mother. Children were more likely to be recommended to live with parents when there was a higher salience of mother’s mental health problems but fewer assessments about access for the mother. While mother’s mental health problems seem to warrant a higher level of intervention from the court, the clinic recommendations indicate that they did not impede parenting skills enough to remove the child.

Clinic recommendations and court decisions about protection orders and placements were most strongly associated with the current situation. While clinic recommendations about protection orders did not predict the first substantive court order, both of these orders were associated with the last order on file. Although court-ordered placement was moderately associated with clinic recommendations, children’s current placement was the strongest predictor for both clinic and court ordered placements.

**Conclusion for Study 2**

Overall, the main findings highlighted important relationships between the clinic and court outcomes concerning court protection orders and children’s placements. The clinic was less intrusive than the court in relation to protection orders and also more likely to recommend children to their parents’ care. They did, however, agree on a substantive number of both court orders and placements. There were more agreements
between the clinic and the court about children’s placements than about court protection orders, with the corresponding rates of 73% and 57%, respectively.

Agreements about court orders, but not placements, were also associated with the salience of father and mother problems. There are three main points about the association of salience with clinic and court agreements. First, in matters where the clinic and court agree about protection orders, the salience of mother problems was higher than father problems, overall. Second, there was an opposite pattern when the court was less intrusive than the clinic: the salience of father problems was significantly higher. Thirdly, when the salience of both parent problems was high, court decision was significantly more intrusive than that of the clinic.

These findings may be suggestive about the differences in legal and psychological understanding about the problems of the parents and how they relate to the best interests of the child. Court protection orders determine the level of supervision and involvement from support services whereas placement decision is a matter of a child’s physical environment. Both placement and protection orders, however, contribute to the decisions about the best interests of the child in the form of parental care and appropriate interventions.

While court, in general, was more intrusive than the clinic, the results illustrated a curious pattern in relation to a group of families where court orders were less intrusive than clinic recommendations. In this group, the striking difference was that the salience of mother problems was significantly lower than in other families (the salience of mother problems was higher overall). By contrast, the salience of father problems was high in this group (the salience of father problems was lower overall). When the court and clinic were in consensus, mother problems were more concerning than father problems, possibly indicating a clearer understanding of the appropriate interventions in
relation to problems experienced by mothers. It may be that the clinic, but not the court, perceive the problems of both parents as equally concerning, whereas the court is more inclined to emphasise the mother’s problems in their decisions. Arguably, the primary carer role attributed to mothers is likely to be embedded in professional interpretations about the child’s best interests.

Another possibility is that the court and the clinic hold different views about the level of intervention required and to a lesser extent, about a child’s placement. While the salience of mother problems was higher in the clinic assessments overall, for example, the salience of father problems was substantially higher when the court disagreed with the clinic, ordered less intrusive interventions and ordered the child to the parents’ care.

The strongest individual predictors for court orders and placements were the current situations. While the results highlight a substantive level of agreement for placements, clinic recommendations about court orders were followed up in only a little more than half of the families. Current orders and current placements were the stronger predictors of both court orders and placements. These results are consistent with the finding that neither the court nor the clinic ordered many changes in the current situation.

Finally, clinicians’ recommended placements and first substantive court orders were also associated with issues related to mothers, particularly with mental health problems and assessments of access arrangements. The court was more intrusive and the clinic more likely to recommend the children to parents’ care when the salience of mother’s mental health problems was high.

Taken together, these results show that the ways clinicians form their opinions, and the ways the court agree with these opinions, are related to only some of the parent
problems – namely, the salience of the mother’s mental health problems and father’s substance abuse. The findings of Study 2 also provide information about how the problems of parents are associated with clinicians’ recommendations that aim to serve the best interests of the child, and how the court uses this psychosocial information in their final decisions.
Chapter 8

GENERAL DISCUSSION AND CONCLUSIONS

The aims of this research were to examine clinicians’ reports with a particular focus on their attendance to the common parent problems of domestic violence, substance abuse, and mental health problems when making recommendations to the court. Clinical assessments in child protection matters are usually about families where parents’ ability to provide good enough care for their children is in question. The specific aims were to identify the patterns in parents’ problems in clinicians’ assessments and recommendations, and to examine how clinicians’ recommendations were related to court decisions after the reports were made.

A content analysis specifically focused on distinctive patterns in clinicians’ mentions of parent problems, and on how these problems were used in clinic assessments (Study 1). A separate set of analyses in Study 2 drew on a careful coding of the levels of salience and concern for the three forms of parent problem for fathers and mothers. This study also examined how clinicians’ references to assessment issues and the salience of the parent problems were related to clinicians’ recommendations and to court decisions about protection orders and children’s placement.

The research was framed by the significance of parent problems in child protection matters in relation to two fundamental guiding principles that are prominent in child protection research and practice. These are the principles of good enough parenting (Azar & Wolfe, 1998; Benjet et al., 2003; Reder et al., 2003), and the best interests of the child, with this latter criterion specifically highlighted by the relevant legislation (CYFA, 2005).

The findings are discussed in four sections: (1) the significance of parent problems in child protection matters, involving (a) their occurrence, co-occurrence and
associations with other issues, and (b) their salience in the reports; (2) clinicians’ identification of assessment issues for these protection matters, involving (a) the nature of assessment issues, and (b) their impact on clinicians’ recommendations and court decisions; (3) recommendations and court decisions; and (4) the overall significance and usefulness of clinical assessments for the court together with future directions for this line of research.

PARENT PROBLEMS

Study 1: Prevalence, Patterns and Impact

The analyses focused on 250 children and their biological fathers and mothers, with three sets of analyses: (1) identifying patterns of parent problems and their relative prevalence (Chapter 5); (2) relating these patterns to child issues and to the clinicians’ assessment issues (Chapter 6), and (3) relating these patterns to clinicians’ recommendations for placements of the 250 children.

Prior research reviewed in Chapters 2 and 3 provided a basis for a holistic approach to analysing the occurrences and co-occurrences of specific parent problems that are frequently present in child protection matters. Chapter 2 revealed that distinct patterns in these parent problems are prominent in families before the court on child protection applications. These patterns are also known to impact on child safety and well-being. Chapter 3 demonstrated that court child protection assessments focus on the different aspects of families that may be impacted upon by these patterns, child safety in particular. They are also invoked in assessments of good enough parenting, a widely used assessment criterion in child protection assessments (Azar et al., 1998; Benjet et al., 2003; Melton et al., 2007).

Hierarchical cluster analyses yielded 11 distinct patterns on the basis of prevalent issues identified in the clinic assessment reports: domestic violence, substance
abuse and mental health problems of fathers and mothers. These patterns were confirmed with further analyses, such that the 11 patterns could be organised into four groups of children with: (1) no mentions of parent problems; (2) only one defining parent problem; (3) more than one problem for either the father or mother; and (4) multiple problems for both parents. As expected, results revealed that the patterns in parent problems were related to child-related issues, clinicians’ identification of assessment issues, and the placement recommendations that clinicians made to the court.

While father’s domestic violence and mother’s mental health problems were the most prevalent and concerning problems for these families, there were specific patterns in the ways these problems occurred and co-occurred in the reports. In contrast, mother’s domestic violence and father’s mental health problems stood out as the least concerning issues, but when taken alone, they were also the only parent problems that were related to clinicians’ recommended placements about parents’ care.

**Domestic Violence, Substance Abuse and Mental Health of Biological Parents**

While the problems experienced by parents are acknowledged in research on child protection matters, no systematic accounts exist of the patterns these prevalent problems take in protection assessments. There are indicators, however, that they occur and co-occur frequently, and that they contribute significantly to child protection matters (Carter & Myers, 2007; Dawe et al., 2008; Semidei et al., 2001).

The present cluster-analytical approach was an appropriate method for examining the complex patterns of co-occurring problems in the families (Henry et al., 2004). Given that a common focus in the clinic assessment is the match between parenting capacity and the child’s needs, it was reasonable to expect that different
patterns in the problems experienced by parents would be associated with clinicians’ recommendations about how to best protect a child.

Consistent with an existing body of research (Bagshaw & Chung, 2001; Booth et al., 2005; Miller & Finnerty, 1996; Humphreys, 2007; Locke & Newcom, 2003; McIntosh, 2003; Worth & Merting, 1997), the results showed that parental domestic violence, substance abuse and mental health were indeed highly prevalent in child protection matters, as identified by clinicians’ reports to the court.

The results also revealed different rates of these problems in relation to fathers and mothers. Father’s domestic violence and mother’s mental health problems were the most prevalent problems in the reports, while father’s mental health problems and mother’s domestic violence were mentioned for fewer families. Substance abuse was mentioned between these two extremes, in relation to half of the fathers and mothers.

These problems of parents formed 11 distinctive patterns that were associated with child-related issues, parents’ involvement with the clinic, clinicians’ assessment issues and recommendations of placements. While previous studies have shown that co-occurring domestic violence, substance abuse and mental health problems are often present in child protection matters (e.g., Barry et al., 1996; Drake et al., 1991; Fulwiler et al., 1997), the current research was able to establish a detailed description of a variety of patterns across these problems.

**Occurrences and Co-Occurrences of Parent Problems**

*Research Question 1* addressed patterns in the three types of problems for fathers and mothers. The 11 patterns derived by the cluster analytical approach yielded an ecologically plausible depiction for the 250 children assessed at the clinic. Cluster analysis is an exploratory measure of naturally occurring hierarchical relationships and should be, at least to some extent, guided by an a priori understanding of patterns in data.
The formal analyses revealed an optimal solution between 9 and 11 clusters; however, the 9 and 10-cluster solutions failed to distinguish an important cluster of children without any mentions of the six forms of parent problem. It was important to separate out children with none of the parent problems to investigate possible reasons why these children were sent to the clinic for assessments.

The analyses concerning Research Question 1 showed that the 11 clusters were distinctly different, not only on the basis of parent problems, but also in terms of how they were related to child-related issues, parents’ involvement, clinicians’ identification of the assessment issues and the recommendations they made about children’s placements. The 11 patterns could be organised into four blocks based on the extent and complexity of parent problems mentioned for the children: (1) no problems; (2) one problem; (3) two problems for one parent; and (4) multiple problems for both parents. These blocks and the distinct features within and between these are discussed next.

**Children with no mentions of parent problems.** The first subgroup of children had no mentions of the six parent problems. In comparison with other children, they were more likely to attend the assessment without their parents. The court clinic routinely invites the biological family unit including the father, mother and relevant children to attend the court clinic assessments. This is important in order to obtain information about the child’s developmental and familial history, and child and parental well-being (Brown, 1999). Common reasons why parents do not attend the assessment may be related to the parents’ role in a child’s life. It is often the case that the parent is not currently involved in the child’s life or that they fail to make their way to the clinic on the assessment day. Consequently, clinicians may not have had access to information about these parents, or the parent issues were not relevant to the context of the assessment. Alternatively, there may have been other issues in the families that
contributed to the well-being of the child on which the court required clarification (e.g.,
a child’s developmental delay, family conflict contributing to child well-being, or
problems with a safe physical environment for the child).

The children with no parent problems, however, had more mentions of child
related-issues, sexual abuse in particular. It seems that protection issues in this cluster
(C1) were not likely to be attributed to parents’ personal problems. Rather, the
protective issues that brought these families to the clinic seem to have been related to
child problems (developmental, psychological, and/or behavioural issues). This supports
patterns of child and parent problems in other studies (Bagshaw, 2001; Buckley et al.,
2007; Ericsson et al., 2007; Lamb & Lewis, 2005; McCrae, 2009; Velleman et al.,
2008). In this scenario, the court might seek clinic assistance in the form of the best
supportive interventions for the carers to supply environments for the child that would
be safer or more capable of managing their special needs.

Alternatively, the cluster (C1) may consist of two smaller subgroups of children:
one where children were living with their family and where protective concerns were
less severe (9 children), and another one where children were not living with their
parents and who might no longer be involved in their lives (9 children). These children
were either in kin care or out of home care, thus, the parents were not part of the
assessment procedures. In both scenarios, it would be reasonable to find fewer
assessments the targeted parent problems and fewer arrangements for access with
biological parents. These smaller subgroups warrant further investigations using more
detailed data than were available in the reports.

**Children with mentions of one parent problem.** Four subgroups involved
children for whom the clinicians mentioned only one of the six problems, either father’s
domestic violence, father’s or mother’s substance abuse, or mother’s mental health
problems. Father’s mental health problems and mother’s domestic violence were only mentioned in co-occurrences with other parent problems.

**Domestic violence.** Father’s domestic violence seemed to be related to the most serious forms of protective concerns. Ackerman et al. (1998) also pointed out that abuse by fathers is more detrimental for child development than abuse by mothers. Not only were these children already removed from their parents, they were also recommended to stay in out of home placements. These children in the present research were also more likely than others to have been sexually abused. These findings are in line with existing evidence showing that sexual abuse is associated with child physical abuse (Goddard & Hiller, 1993).

According to the functional-contextual framework of child protection assessments proposed by Azar and others (Azar & Benjet, 1994; Azar et al., 1998), clinicians’ decisions need to take into account the severity and forms of violence and abuse. Kuehnle et al. (2000), for example, proposed four factors that contribute to the interpretations of violence in child protection: (1) the parent; (2) the environment; (3) the child; (4) and relationships between the parent and the child. In this sense, the findings of Study 1 suggest that child well-being was significantly impaired not only by the presence of violent fathers, but also their exposure to sexually inappropriate environments and to problems related to their own psychological well-being. A particularly concerning issue was that fathers who were violent were also most likely to be the alleged or actual perpetrators of sexual abuse.

Although father’s domestic violence is a reasonable cause of significant harm for a child, results from this study revealed that neither fathers nor mothers were deemed as appropriate carers for their children when the only problem was violence. Given the multiple sources of stress commonly present in families where domestic
violence is present (Azar et al., 2005), mothers’ caretaking abilities may have been affected by fathers’ violent or aggressive behaviours such that they were deemed equally inadequate to provide good enough care for the child.

Substance abuse. Substance abuse was a defining problem for two groups of children, one in relation to fathers and one in relation to mothers. Consistent with previous studies (e.g., Dawe et al., 2008; Ornoy et al., 1996), the current research showed that mentions of parental substance abuse was associated with neglect. Parents’ substance abuse commonly translates into neglectful behaviors through their lifestyle and the environments they provide (Swadi, 1994). The physical environment the parents are able to provide for their children is often impaired as a result of substance abuse (Ammerman et al., 1999; Finkelhor et al., 1990; Magura & Laudet, 1996; Williams-Petersen et al., 1994; Zuravin, 1998).

The clinicians’ focus in substance abusing families was most likely about children’s placements. Children of substance-impaired fathers were likely to be recommended for changes in their placement arrangements. They were, in fact, likely to be recommended for reunification with their mothers. These findings are partly consistent with previous studies in which parents’ substance abuse is linked to the removal of a child and low reunification rates (Beeman et al., 2000; Besinger et al., 1999; D’Andrade, 2010; Murphy et al., 1991; Leventhal et al., 1997; Marcenko et al., 2000). It is possible that the court had initially removed the child from an environment where the mother was living with a substance-abusing partner but reunification was an option if the mothers had improved their home environments.

The evidence about substance abusing fathers’ parenting capacity is mixed. While there are not many studies about this impact (McMahon & Rounsaville, 2002), some contradictory findings suggest that drug abusing fathers show fewer punitive
behaviours and more involvement in their children’s activities than expected (Kandel, 1990). Others suggest that the quality of parental discipline is poorer in comparison to parents who are not substance abusers (Tarter et al., 1990). A father’s ability to provide care for his children, however, may be related to other factors, such as a supportive partnership or the father’s level of involvement in their children’s lives.

In these data, children of substance abusing parents were most likely to attend the assessment with the parent who had the substance abuse problem, strongly indicating the parents’ motivation to be involved in their children’s lives. Ghaffar et al. (2011) showed that in comparison to domestic violence and mental health issues, more positive outcomes were related to parents addressing problems with drugs and alcohol.

In line with this evidence, Fraser et al. (2009) found parents are more likely to be motivated to change their substance abuse habits to continue, or to resume caring for, their children. They also found evidence of parental appreciation of direct personal help by drug and alcohol services. The results of the current research possibly reflect the clinicians’ interpretations of parents’ motivation to change their habits to resume caring for their children.

**Mental health.** Mother’s mental health problems were likely to focus on specific problems related to the child. In line with previous studies (e.g., Beardslee & MacMillan, 1993; Leschied et al., 2003), these problems included a variety of behavioural and emotional issues, neglect and sexual abuse. However, some research has established a contradictory account of how mother’s mental health is linked to child well-being (Beardslee & MacMillan, 1993; Leschied et al., 2003; Melton et al., 2007).

While parental mental health problems do not necessarily lead to protective concerns (Cohn & Campbell, 1992; DeMulder & Radke-Yarrow, 1991), common factors that exacerbate negative child outcomes include some types of mental illness,
the availability of social support and the child’s special needs (Azar et al., 1998; Benjet et al., 2003; Melton et al., 2007). The data at hand, however, were not detailed enough to capture the range of mental health issues that may have contributed to protective concerns.

**Children with mentions of multiple parent problems.** Six groups of children were characterised by multiple parent problems. In two of the groups, problems were mentioned only in relation to fathers or mothers (Block 3). The most concerning patterns, however, seemed to be related to three subgroups involving multiple and co-occurring problems for both parents (Block 4). Parental substance abuse, in particular, significantly distinguished between the subgroups.

**Substance abuse co-occurring with other parent problems.** It is widely established that substance abuse provokes domestic violence and can exacerbate mental health problems (Barry et al., 1996; Dassori et al., 1990; Fulwiler et al., 1997). In fact, these family issues are consistently shown to share the same etiology and common contextual factors that further impact on the parents’ capacity to provide good enough care for children (Fergusson et al., 2007; Kendler et al., 1993; Lynskey et al., 1998; True et al., 1999; Tsuang et al., 1998).

When substance abuse co-occurred with domestic violence or mental health problems, it was also related to, in particular, to both current and recommended placements in kinship care. This is consistent with previous studies where substance abuse was strongly related to the removal of children from their families (Besinger et al., 1999; Leventhal et al., 1997; Marcenko et al., 2000), particularly to kinship care (Beeman et al., 2000).

It seems that kinship placements may result in higher placement stability than other out of home placements. It may be that children with problems associated with
both parents’ substance abuse have already suffered detrimental instability in their placements. Children in kinship care reunify at a slower rate than children in other out of home care placements, but are also less likely to re-enter the child protection system than children with other subsequent placements (Courtney, 1994; Davis et al., 1997; Goerge, 1990; Westat and Chapin Hall Centre for Children, 2001).

Additionally, the protection system is required to make efforts towards conserving the child’s bond with their family (CYFA, 2005). When both parents have a history of complex issues surrounding substance abuse, the family relationships may be best maintained by placing the child with extended family.

**Mental health problems co-occurring with other multiple parent problems.**

Previous studies (McConnell et al., 2006; Baer et al., 2003) have found that parents’ mental illness or mental disability can be a disadvantage when interacting with the protection system. In the families referred to the clinic, both parents’ mental health problems were linked to better clinic attendance and higher reunification rates. It may also be that clinicians particularly focused on mental health issues in assessments when they considered a possibility for the child to live with his or her parents. The two groups where both parents had mental health problems were similarly associated with placements with both parents; despite one group having mentions of all parent problems (C11) as opposed to only father’s domestic violence for the other (C8).

In sum, the patterns in the multiple problem subgroups highlight some important considerations about the families that were referred to the clinic. The least prevalent parent problems, father’s mental health problems and mother’s domestic violence, only occurred in conjunction with other parent problems. Substance abuse, however, had the widest variety of patterns. For some children it was only present as a stand-alone problem for one parent, but for other children, it co-occurred with other types of parent
problems: if both parents had substance abuse problems, other problems were also present. While both parents’ substance abuse was linked to kinship care placements, both parents’ mental health problems were closely associated with family reunification. Despite their mental health problems, these parents routinely attended the clinic assessments, as opposed to other subgroups. This seemed to be a crucial factor in clinicians’ placement recommendations.

**Associations of Parent problems with Child-Related Issues**

Although a child’s problems may not always stem from parental deficits (Hynan, 2003), the complex ways child-related issues and parent problems were associated in these data seem to mirror the parents’ abilities to protect their children from harm. All three forms of parent problems were related to children’s emotional and physical harm in the form of neglect or exposure to abuse, as found in other studies (e.g., Christoferssen & DePantifilis, 2009; Martinez-Torteya et al., 2009; Moehler et al., 2006; Puckering, 2004). These links were also in line with placement decisions (Baer et al., 2003; Booth et al., 2005; Department of Human Services, 2003; Fenton, 1992; Forrester, 2000; Irwin et al., 1998; Miller & Finnerty, 1996; Taylor et al., 1991; Young, 1998).

There were three distinct ways in which parent problems were associated with child-related issues: (1) the absence of parent problems; (2) father’s domestic violence; and (3) both parents’ substance abuse.

First, when there were no mentions of parent problems (C1), the problems addressed at the clinic were more likely to be related to the child. Children who attended the assessment without parent problems were more likely to be assessed for sexual abuse and most likely not to have their biological parents present for the assessments.
The small size of this subgroup, however, is only a small indicator of the prevalence of parent problems in the referred sample.

Second, while sexual abuse was strongly present in families where there were no mentions of parent problems, it was also consistently associated with father’s domestic violence with or without both parents’ mental health problems. Indeed, physical abuse commonly coincides with other maltreating behaviours (Australian Bureau of Statistics, 2005; Appel & Holden, 1998; Australian Institute of Criminology, 2001; Edleson, 1999; Laing & Bobic, 2002) and with child sexual abuse (Goddard & Hiller, 1993). In addition, children with only one dominant parent problem were more likely to be sexually abused by immediate family members (mostly fathers), while children with multiple problems were more likely to be sexually abused by someone outside the family.

Third, girls were at higher risk of neglect when fathers had substance abuse problems, whereas boys were at higher risk of neglect when mothers had substance abuse problems. Neglected boys were also more likely to have co-occurring behavioural problems. Other studies (Ornoy et al., 1996; Kienberg et al., 1995) have reported similar findings about the co-occurrence of neglect and behavioural problems, particularly in the face of parents’ drug abuse. Child neglect is often caused by other issues that coincide with parents’ substance abusing lifestyles, such as exposing children to strangers, leaving them without adult supervision and mental health issues exacerbated by alcohol and drug use (Dawe, Harnett, Staiger, & Dadds, 2000; Klee, 1998; The National Clearinghouse on Child Abuse and Neglect Information, 1993).

**Study 2: Salience**

In Study 1, the focus was on the occurrence and patterns in the common parent problems related to child well-being and protective concerns. Study 2 involved a more
detailed investigation into the clinicians’ level of concern for each problem, using a salience measure especially developed for this study. The analyses then focused on whether the salience of problems was related to clinic recommendations and court decisions about placements and protection orders.

Study 1 showed that the two problems most consistently related to clinicians’ placement recommendations were mother’s domestic violence and father’s mental health issues. Recommendations for placement with parents (rather than in out of home care or kinship care) were more likely when these two problems were present. They also contributed to the regression equation with the negative effect of access issues, and the positive effect of protective concerns for the child and the current placement. Study 2, however, added that these two problems were not only the least prevalent, but were the least salient and least concerning issues in the clinicians’ reports to the court. It would seem that the clinicians saw these two problems as not adversely affecting the parents’ ability to provide adequate care for their children. It also seems reasonable to infer that these two infrequent problems did not adversely impact on interpretations of good enough parenting for these clinicians.

The Salience of the Mother’s Role in Child Well-Being

Interestingly, when using the salience measure in Study 2, as opposed to only mentions of occurrence (Study 1), the mother’s mental health problems became the most prevalent and concerning parent problem, and the only parent problem contributing to the regression analysis for placement recommendations. The higher the salience of mothers’ mental health problems, the more likely it was for clinicians to recommend placements with parents. The salience of parent problems, however, did not contribute to court-ordered placements, although the salience of fathers’ substance
abuse, together with mother’s mental health problems, contributed to the likelihood of court orders being more intrusive (custody and guardianship orders).

The significant role of the mothers in child safety is widely established (e.g., Leschied et al., 2003; Tebes et al., 2001; Woodcock & Sheppard, 2002). The fathers’ role, however, is more controversial (e.g., McMahon & Rounsaville, 2002; compared with Tarter, 1990).

While previous research links mother’s mental health problems to concerns about inadequate parental care, there are contradictory accounts about its impact on child well-being (Cohn & Campbell, 1992; Cohn et al., 1986; DeMulder & Radke-Yarrow, 1991; Melton et al., 2007). The current research gives a snapshot about this prominent issue, which featured in more than half the families assessed at the clinic. It was systematically associated with clinicians’ recommendations and court decisions. This is illustrated in two ways. First, the overall concerns about mothers’ mental health were higher when the clinic made recommendations about parents’ care. Secondly, court orders were more intrusive for families whose mothers had highly salient mental health problems, indicating a higher level of involvement from the protection system after the clinic assessment.

These results do not agree with some previous studies that show that parents’ mental health problems are strongly linked to lower reunification rates and lower levels of commitment from parents (Booth et al., 2005; Miller & Finnerty, 1996; Taylor et al., 1991). Instead, they suggest that clinicians view mothers’ mental health as a type of problem that may not always impede good enough parenting. One clinician, for example, in recommending children to be reunified with parents from out of home care in the face of the mother’s highly salient mental health problems, saw her parenting abilities as adequate:
This assessment suggests there are positive attachment relationships between the children and parents, especially mother. It needs to be kept in mind that this is a description of the relationship which appeared warm and positive. While this is positive, it needs to be kept in mind that the main protective concern is the parents’ capacity to maintain a safe and adequate environment, not marred by drug abuse or psychiatric disturbance. However, on the basis of these positive relationships, I would suggest the overall protective goal be one of returning the children to the parents’ care and arranging to provide maximal support to optimise this family’s capacity to parent the children. This should involve a broad range of interventions. (Case 25).

It seems that in these reports, the clinicians may specifically highlight mental health issues for mothers in an effort to guide the court about how to best provide support for these mothers, and consequently provide better care for their children, a protective goal in the legislation (Shaw, 2006). One potential explanation underlying these patterns is that when mothers are experiencing a wide range of problems, the practitioners may be clearer than the court about the kinds of arrangements and services that can benefit the family. Alternatively, the legal and psychological understanding about a mother’s ability to provide adequate care for children may be in closer agreement than understanding about a father’s. The problems of fathers, then, would not be emphasised in courts, as the traditional view focuses on mothers as primary carers. Consequently, child safety and well-being may be attributed to the well-being of mothers in legal accounts of the child’s best interests, whereas the psychological view holds that the role of fathers and mothers is more equal.

Placement recommendations need to be taken into account in conjunction with recommendations for intervention strategies that would support children and their
carers. More specifically, when it is thought a child should be with one or more parents or with kin, the assessment issue of parental access comes to the fore. Mother’s mental health problems seem to be particularly related to placement and assessment issues as a set.

The salience of mothers’ contributions to child well-being and particularly of mother’s mental health points to the usefulness of going deeper in the coding archival data. The development of the salience measure and the high level of interjudge reliability are a small step towards combining quantitative measures with thematic coding in future content analyses.

This measure brought to light clinicians’ emphases and contributed to the explanation of clinicians’ recommendations for placement. When combined with the clinicians’ identification of underlying assessment issues, it forms a basis for further analyses of clinicians’ assessments that can hopefully include information directly that concerns their inferencing procedures.

**Assessment Issues Identified in the Reports**

While legal principles and clinical guidelines provide a broad framework for assessments in court child protection matters, a clinician’s decision processes and outcomes are also shaped by how they define and interpret the individual case (Hill et al., 1995; Lawrence, 1991). Ideally, clinical assessment processes are based on problem definition, so that the clinician can form an initial hypothesis that can be revised in the course of data collection. The assessment issues found in the current research reflected crucial questions closely associated with the protection of the child: placement, specific protective concerns (e.g., physical abuse, neglect, parents’ antisocial behavior), parents’ access arrangements, and child-related problems (e.g., behavioural or emotional problems, high care needs).
These data were in the form of actual reports, so it was not possible to specify the processes used by these practitioners, compared with Lawrence’s (1991) online process analyses. The clinicians’ reports, however, pointed out to the court defining issues for each family, and in the summation recommendations they also referred back to the assessment issues they had identified. This identification of assessment problems informs possible solutions and allows clinicians to focus on relevant material in providing evidence to the court. Accordingly, clinicians’ identifications of presenting problems need to be considered in distinct ways. It was important to examine how they were related to: (1) the parent problems; (2) the clinicians’ recommendations about placements; and (3) their possible contributions to court decisions.

**Associations of Parent Problems with Assessment Issues**

The ways clinicians cognitively frame their assessments guide what risk factors they use and the case characteristics they address in formulations, final conclusions and recommendations (Elbogen & Huss, 2002; Grisso, 1996; Heilburn, 1997). The issue of placement, for example, was commonly identified in families where parental substance abuse was a dominating problem, whereas placement issues were less frequently addressed in families where clinicians invoked none of the parent problems. In families where problems were co-occurring and more complex, the assessments concentrated on access arrangement for parents rather than on placements. The questions of interest, then, are related to the effect on children and families of more and less frequent visits with non-custodial parents.

In families with multiple problems, the assessments were also less likely to focus on child specific issues, indicating that the protective issues were more likely to be related to the parent than the child. This was also evident in the group with no parent problems: the assessments were more likely to be about child specific problems.
Clinicians’ identifications of these assessment issues were treated as the psychological focus and were also expected to link to their clinical formulations and recommendations. 

The 11 cluster groups consisted of different patterns of problems associated with assessment issues, with considerable variability for boys and girls. There were fewer assessment issues of access identified for boys than for girls when there were multiple parent problems. There were more assessments of specific protective concerns (e.g., exposure to significant harm, physical abuse, neglect) for boys than for girls when fathers had multiple problems.

These protective concerns for boys and girls contributed to clinicians’ recommendations about placements. The more protective concerns, the more likely the clinicians were to recommend placements to parents’ care, often accompanied by a suite of appropriate services being recommended. In contrast, assessment issues related to access arrangements for fathers and for mothers were most likely to be identified for children who were recommended to live in out of home care. In line with the significance of mothers’ contributions to children’s lives, the issues of mother’s access contributed to both the clinicians’ recommendations for the children’s placements and the intrusiveness of the court’s protection orders.

As proposed by Guy (1990) and Hill et al. (1995), the current results showed that initial identifications of presenting problems were associated with recommendations made by the clinicians for children’s placements and court orders. In families where the assessments focused on access arrangements with mothers, the court orders were more intrusive, and clinicians’ recommendation of placement was towards out of home care. This suggests a more serious level of protective concerns for families where access for the mother was assessed.
CLINIC RECOMMENDATIONS AND COURT DECISIONS

Protection Orders

Not many studies have examined how courts use expert clinicians’ recommendations in child protection matters. Some empirical evidence (Butler et al., 1995; Jamieson et al., 1999) suggests an agreement rate between 60% and 70% in assessments involving children and adolescents, which is somewhat higher than that found in the current research. Research Question 3 addressed to what extent the court agreed with the clinic recommendations. Court decisions about protection orders were in agreement with clinic recommendations in just under 60% of the recommended orders (57%). The highest agreement was about custody orders, followed by less intrusive supervision and interim orders. The court orders were more intrusive than the clinic recommendations, with the exception of the very first order after the assessment. It is often the case that the court makes an interim order after clinic assessment to allow enough time for the decision authorities to make long-term decisions about the best interests of the child. It also enables the parents to respond better to possible requests and conditions addressed in the clinic assessments.

Not only were the court protection orders more intrusive than clinic recommendations, but the trend also grew progressively stronger over time. Children whose protection applications came back to court after an order was made were more likely to be ordered more intrusive orders. The longer protection matters stayed in the system, the more likely it was for children to be placed on guardianship and permanent care orders. Vulnerable children are often exposed to stressful child protection procedures longer and more frequently because the problems of their parents cannot be resolved or are not adequately addressed (Bishop et al., 2000). The court may seek reunification and allow the parents time to deal with their problems. The types and level
of problems clinicians identify in the protection matters, then, are aimed at providing courts with relevant information to provide appropriate support for families in order to help the child.

**Children’s Placements**

**Clinicians’ recommendations.** While protection orders determine the level of intervention and support for families, children’s placement is an important question in protection matters. When parents’ care is no longer considered good enough, the child may be removed from their family’s care, a decision that is only warranted when a child is at risk for significant harm and protective interventions have not led to improvement (Melton et al., 2007). Scott and Swain (2002), for example, pointed out that while parents had problems, these did not automatically translate into protective concerns. Clinicians’ recommendations for out of home care, then, may be considered as one indicator of professionals’ opinions that parental care is or would be inadequate (Azar et al., 1998). Naturally, these are not the only concerns pointing to family dissolution. The associations revealed in the present analyses also point to the relevance of clinicians’ differential interpretations of violence, substance impairment and psychiatric illness in relation to placement recommendations. These data indicate the need to take a finer view of the impact of family issues on expert practitioners’ opinions concerning how children’s safety and stability may best be arranged and supported. As far as can be determined, there is no information about the factors promoting success in securing appropriate lasting environments for children (Lawrence et al., 2010).

Since the different patterns in parent problems contributed to clinicians’ recommendations about placements, it would be reasonable to expect that children whose parents had mentions of multiple parent problems would be less likely to be placed in their parents’ care. This was not, however, the case. In fact, children whose
parents had no problems and children who had all parent problems yielded similar patterns in placement recommendations: both groups were associated with recommendations to parents’ care. While children with no parent problems were currently living with parents, children with all problems were more likely to reside in out of home care at the time of the assessment. Reunifications were likely to be recommended for these latter families with multiple and complex problems (C11), whereas children in the no parent problem group (C1) were simply recommended to stay in their current placements. While children with multiple problems associated with both parents’ substance abuse tended to be seen as candidates for kinship care, father’s domestic violence was the only single pattern that was strongly linked to out of home placements.

These results are not consistent with previous studies that suggest all three forms of parent problems are strongly associated with out of home placements (Horwitz et al., 2011; Lindsey, 1992; Zuravin & DePanfilis, 1997). It may be that in these families, although present, the problems were not considered serious enough to warrant removing children from their families. It is important to note, however, that these clinicians recommended multiple and varied interventions and support systems to enhance parents’ ability to care for children, a goal that is clearly communicated in the legislation. They recommended, for example, such services as individual therapy for the parent or child, in-home carers to assist parents, cleaners, and respite care arrangements.

**Court Placement Decisions.** The point of clinicians’ recommendations is to inform the court in matters where they require assistance with psychosocial information about what is in the child’s best interests and what will secure adequate or good enough care and safety for an individual child. Court decisions agreed with three quarters of the clinicians’ recommendations for the children’s placements, although magistrates were
less likely to place children with their biological families than the clinic in the next court hearings. The strongest predictors of court placements were the current and recommended placements, neither the salience of parent problems nor assessment issues. This may point to a reluctance to disrupt children’s lives if their existing circumstances were considered adequate. Both the clinician and the magistrate are well aware of the complexities involved in changing children’s living environments, and like the clinic, the court is committed to stability in children’s lives (Coate, 2001).

The agreement between the court and the clinic was higher in relation to placements than in relation to protection orders. When they did not agree, clinicians were more likely than the court to recommend children to live with their biological family. While neither the court nor the clinic suggested many changes in the current placements, they were more likely to agree about kinship and out of home care than about parents’ care. These results mirror the different views the court and the clinic may hold about factors associated with adequate levels of parental care. In relation to placements with parents, the best interests principle may raise different responses from legal and psychological decision-makers. Since the legal principles and clinical guidelines are not completely clear about the best interests of the child (Van Zyl, 2007), there are various ways of interpreting this criterion. At the least, the court and the clinic tended to emphasise the stability of placements in their decisions.

Stability was more prominent than change in these recommendations. It was also more prominent in court placement decisions. In most cases, the recommendations were to leave the child where they were unless moving them would be in the child’s best interests. Most saw this criterion as involving a move towards family reunification. This principle is explicitly the default position in the CYFA (2005).
In closing, it is important to note that there were a number of issues that lie beyond the scope of this research. For example, the current set of analyses was directly concerned with parents’ common, co-occurring problems. These problems do not cover all potential problems in the parents. For example, the data do not include issues such as parents’ criminal behaviour and incarceration. At a systemic level, family poverty and homelessness also may exacerbate the effect of these three types of co-occurring problems. The three parent problems that were included in this research, however, are the most common issues in families already in the protection system.

Similarly, these analyses have not focused on the possible promotive factors residing in families and parents that allow good enough parenting, despite the presence of other problems. In their own right, the analyses of child behaviour problems, sexual abuse and neglect warrant concentrated examination. The present analyses point to the value of further studies of clinicians’ reports with these different concepts and their effects on families as a specific focus. Some of these analyses, ideally, would cover more severe but less common parent problems (e.g., incarceration). Some could focus specifically on promotive and positively contributing factors (e.g., social networks for the family, parental recovery or willingness to change). This research was the first step towards identifying common parent problems and their effects.

THE CONTENT-ANALYTIC APPROACH

The analyses carried out in these studies specifically point to the value of content analytic techniques and using these techniques to analyse archival records. This is especially the case when the records are produced by one group of experts in one institution for another group of experts in a related institution. The data in the current research were able to focus on clinic assessment reports in their original form, as they were presented to the court.
The Children’s Court Clinic of Victoria was established to provide expert advice to the court on protection matters when psychological information is needed to assist magistrates in making decisions about the safety and best interests of the child. Through their recommendations, be it on orders or placements, the written reports of clinicians are focused on assisting the court to understand the interplay of family circumstances involved in protection applications currently before the court.

The analyses used in this research focused on the content of clinicians’ reports. The limitations in using retrospective, archival data are present. The reports are the products of clinical reasoning processes and due to the nature of archival research, those reasoning processes could not be examined. There are, however, techniques for accessing expert reasoning as it occurs (e.g., of magistrates’ reasoning inside and outside the court; Lawrence, 1991).

Clearly, these analyses are limited in their scope. The salience measure was designed as a first step to go deeper in the clinicians’ reports than simply addressing the prevalence of the three parent problems. Within its limited scope, it pointed to some differences in clinicians’ levels of concern about each problem. The measure points to the value of going beyond instances to valences in further content analyses.

The whole set of analyses was guided by concepts and models that are prominent in the child protection literature. Their specific focus was justified by previous research and theory, agreeing with Smith’s (2000) claim that content analyses should be formulated in advance based on specific criteria. The treatment of the data also met Lee and Peterson’s (1997) requirement that coding should be checked for reliability. The cross-coding of the parent problems and other features of the data showed that the working concepts could be used by another researcher.

The parental problems were conservatively coded. A problem had to be
mentioned by more than one source to be attributed to an individual parent. Self-admission but not self-diagnosis was admitted. Reports and attributions of a problem to a father or mother were accepted only if they were mentioned in two or more sources. For example, if a mother attributed violence to the father, with no further corroborative mentions, then violence was not attributed (i.e., coded as a mention) to that father. This conservative approach also meant that violence or substance abuse could be attributed to a parent in any part of the family’s history. They may have now disappeared from family circumstances.

A conservative approach to the content of the reports revealed in the current research may warrant checking the present findings using alternative approaches (e.g., interviewing, observing clinicians). In the field of child protection, however, it is the report itself that is significant. The court may request a clinician to explain the conclusions or recommendations in the reports in court, but that does not always happen. The assessments and the recommendations are essentially written materials. The analyses of those written resources, then, carry a significance of their own. Court files contain a number of reports made by various professional persons. The clinic reports have a special status, because they are requested by magistrates, and because they are made with the clear aim of assisting magistrates with their deliberations.

**FURTHER DIRECTIONS AND CONCLUSION**

The results of the current research provide an account of how the problems and difficulties of children before the court are closely tied to the problems of their biological fathers and mothers. Future research could examine the specific problems and dynamics of extended families that come to the clinic, especially given that grandparents are often invited to clinic assessments. It may also be beneficial to compare the issues of families that the courts do not refer to the clinic with those of
families they do. The results of such analyses may be able to illustrate the types of families for which the magistrates require assistance and potentially provide them with tools to better understand the issues with which such families present. Understanding how expert clinicians identify the problems and issues pervading in protective matters is a step toward understanding more about the factors that make children and their families vulnerable.

The main findings shed light on some of the key issues involved in how psychologists and psychiatrists express and present their assessments and recommendations to the court. The clinicians who work at the Children’s Court Clinic of Victoria are expert professionals who on the one hand conduct their work using psychological expertise, but on the other, are equally required to understand how the law operates and how the state child protection system is able to support children at risk in troubled families. The families that come to the court clinic for assessments have often suffered from extreme adversities across generations, and yet some parents retain the capacity to establish a nurturing environment for their children with appropriate supports in place. Other parents can no longer provide good enough care to serve the best interests of their children.

From another perspective, parents’ problems may be more extensive than documented here. The group of children (C1) for whom clinicians did not mention any of the six forms of problems specifically presents some interpretive difficulties. Not all parents of children attended the assessments. However, as suggested earlier, it seems to be that the lack of parent problems is what has brought these 18 children into the same cluster in the cluster analyses. The nine children living without their parents had more child-related issues, which make them difficult to manage in out of home placements. As suggested earlier, some parents were not involved in their children’s lives. In
contrast, the protection applications for nine children in this cluster who were living with one or both of their parents may have been unwarranted. This is sometimes the case when allegations are made against the family.

In brief, with some children in this cluster, the clinicians may have been working without full information on these families, and with others there may have genuinely been no parent problems. In future studies, it would be useful to combine other sources of information with the details available to the clinicians. This, however, requires a different study than a content analysis. It would require additional research questions, methods and resources.

These analyses reveal further directions and further analyses that would add to the value of examining clinicians’ reports, particularly for any that come back to the clinic for further assessments. Researchers would be able to trace improvements or deteriorations in the problems parents were experiencing. This would give evidence of the outcomes of the clinicians’ reports after support services have aimed to improve the parent or child functioning, for example. At the same time, however, it should be noted that the first level outcome of these clinical reports is their presentation to the children’s court. It would be useful to continue our initial interviews with magistrates about their referrals now that there are findings on clinicians’ recommendations. It would also be useful to interview magistrates with additional questions, such as, why they disagree with some recommendations and agree with others.

It would also be beneficial to discover how the clinicians’ assessments and recommendations are used by protective services now that these reports are more widely available (after the CYFA 2005, clinicians’ reports were made available to DHS). The ultimate form of follow-up would be to trace the subsequent development of a protective matter over time. A developmental perspective emphasises the value of
understanding what happens in an individual’s life over time. Such a developmental study, however, may be difficult to mount within different parts of the protective system. It would, however, yield the kind of systemic approach that could illuminate how the processes and outcomes of different professional groups contribute to understanding and changing the life circumstances of vulnerable children.

In conclusion, the magistrates in the preliminary study (Chapter 1) were looking for independent and expert assessments about children and their families about a variety of issues (psychological information, placement arrangements, best interests of the child) in relation to child protection matters. The two studies of this research reveal that parent problems were prominent and significant in the clinicians’ reports on psychosocial issues and in their recommendations about the protection of children. Not only were common parent problems important in these clinicians’ assessments but they were systematically related to other family issues and to clinicians’ recommendations of court orders and decisions.
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Appendix A

Coding Rules for Six Types of Parent Problems

Coding Rules for Six Types of Problems Domestic Violence, Substance Abuse and Mental Health Problems for Fathers and Mothers

Each child is assigned a binary (present/not present) code for six types of parent problems including domestic violence, substance abuse and mental health for biological mothers and fathers.

In some reports there are many mentions of the problem, e.g., the whole assessment might concentrate on assessing. The child will be allocated ‘present’ code for each of the six problems mentioned in the report.

The parent problem can be mentioned anywhere in the report. In some reports there may be only one mention in the background section, e.g., “(...) protective concerns have been related to both parents’ substance abuse and mental health issues”. If this is the case, the child as assigned ‘present’ for both mother and father substance abuse and mental health issues, as it has been mentioned a concern at some stage.

It is possible that there is more than one child in the report; each child is assigned their own codifications. Sometimes there is more than one father for the sibship, and the siblings are assigned a different code. Most reports with multiple children, however, have the same parents, in which case each child is assigned exactly the same codes.

Exceptions:

In some cases parents or other family members blame one another of domestic violence, substance abuse or mental illness to better their own position or to obtain the custody of the child. In cases where one person claims the existence of the problem and one person denies the problem, the problem is coded ‘not present’. If there are more people alleging the problem than those who deny it, the code is also ‘not present’ (a conservative estimate, not attributing problems as the default).

For example, a child does not want to live at home and is claiming that his father is exhibiting aggressive and violent behaviour in conjunction to father denying the allegations and clinician not observing any evidence of aggression or violence. Due to the lack of evidence, domestic violence for father is coded as ‘not present’.
Coding definitions

1. Domestic Violence (DV)

*Any mentions of aggressive behaviour that results in emotional harm or physical injury to a family member.*

*Domestic violence can include aggression towards a child, a partner, another family member, and/or property. Threatening with a gun or an attempt to kill a person also falls under domestic violence. Violence does not necessarily be against the child or witnessed by the child, it is the characteristic of the individual parent.*

Under Australian law use of the term "domestic violence" refers to violence committed by a partner and includes physical injury, intimidation or serious harassment, wilful damage to property, indecent behaviour without consent, or a threat to commit any of these acts (Alexander, 1993). For the purposes of this study we extended the definition to include children, any other family members in the home environment and property destruction as described in the *Family Violence Protection Act 2008* according to which ‘family violence’ involves engaging in certain types of behaviour toward a ‘family member’. The term ‘family member’, is defined in s 8 of the Victorian Act to extend to the following persons:

- a person who is, or has been, the relevant person’s spouse or domestic partner (as a person in a registered relationship or an adult to whom the person is not married but is in a relationship as a couple where one or each person provides personal or financial commitment and support of a domestic nature);
- a person who has, or has had, an intimate personal relationship with the relevant person (whether or not it is sexual in nature);
- a person who is, or has been, a relative of the relevant person;
- a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis;
- a child of a person who has, or has had, an intimate personal relationship with the relevant person;
- any other person whom the relevant person regards or regarded as being like a family member if it is or was reasonable to regard the other person as being like a family member having regard to the circumstances of the relationship, including matters such as social and emotional ties, whether they live together, recognition of the relationship in the particular community, the duration of the relationship, financial dependence, and provision of care and support.

Examples:

‘DHS reports indicate a multiple domestic violence incidents between the mother and the father in the last two years. Children have been impacted by the parents’ volatile relationship’
*(Coding: ‘present’ for both father and mother)*

‘Father has suffered from anger management problems during access with children’
*(Coding: ‘present’ for father)*

‘Mother denies father’s claims that she has been emotionally abusive towards children’
*(No other mentions, coding: ‘not present’ for mother)*
2. Substance abuse (SA)

Any mention of current or history of concerning patterns of alcohol or drug abuse:
- Any illicit drugs
- Daily alcohol use
- Dependence on any substance including prescription medication
- Use of prescription medication for beyond prescribed dosage
- Alcohol use that results in difficulties in parent’s interpersonal relationships, adequate parenting, child safety, physical or mental health.
- DSM-IV definition of substance abuse and dependence:

Substance abuse: For the purpose of coding, a widely recognised definition from DSM-IV was adopted (APA, 2000). Their definition is as follows:

‘Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period, including:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)’

Substance dependence: According to the DSM-IV, substance dependence is a pattern of repeated self-administration of a substance characterised by, and resulting in one (or more) of the following that lead to significant impairment and distress in the past 12 months (APA, 2000).

1. tolerance,
2. withdrawal
3. compulsive drug taking

For coding, both substance abuse and substance dependency as described in DSM-IV are taken to indicate substance related problems. There may be no difference in the material available to clinicians to separate the two. Substance related problems include clinician’s mentions of mother or father’s history of

a. Alcohol related dependency or abuse that impairs the parent’s every-day functioning, see DSM-IV definition below (APA, 2000)
b. Any illegal drug abuse (ref. list of illegal substances in Victoria)
c. Prescription drug dependency or abuse, beyond therapeutic dosage, or recreational use, as cited in DSM-IV (APA, 2000).
Examples:

‘Mother and father had drinking and left the children home alone over night unpsupervised’
(Coding: ‘present’ for father and mother)

‘Mother admitted that smoking marijuana a few of times a week when the children are asleep’
(Coding: ‘present’ for mother)

‘Although father had been seeing a drug and alcohol counsellor, he admitted that he has only been off alcohol for two weeks’
(Coding: ‘present’ for father)

3. **Mental health problems (MH)**

Any mention of current or previous
- Mental health diagnosis as specified in DSM-IV (APA, 2000),
- History of use of psychotropic medication prescribed by a doctor, or
- Clinicians’ mentions of symptoms consistent with any mental health diagnosis such as postnatal depression or suicide attempts (excluding intellectual and cognitive dysfunctions).  
- Even if the clinician reports that the diagnosis or symptoms with the diagnosis as not incapacitating, are coded as an incident.

Examples:

‘Mother’s history with mental health services was extensive, although currently her mental state appeared stable’
(Coding: ‘present’ for mother)

‘He (father) had been suffering from depression when the children were taken into care 2 years ago’
(Coding: ‘present’ for father)

‘Mother denied any current hallucinations but DHS reports indicated that she had been hospitalised only three months prior to the protective intervention’
(Coding: ‘present’ for mother)


Appendix B

Coding rules for the Salience of Domestic violence or Substance abuse or Mental health Problems

(For father or mother in Clinicians’ Reports to the Children’s Court of Victoria)

Table B1

*Coding Rules for Three Levels of Parent Problems, Domestic Violence, Substance Abuse and Mental Health Problems for Fathers and Mothers in Hundred-And-Thirty-Eight Reports*

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Salience Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There are no mentions of the parent problem for father or mother in the summaries</strong></td>
<td>None - 0</td>
</tr>
<tr>
<td>A low level mention involves:</td>
<td>Low-level - 1</td>
</tr>
<tr>
<td>- Mention without an <strong>inference</strong> by the clinician</td>
<td></td>
</tr>
<tr>
<td>(e.g., mother has a history of cannabis when young; DHS reports some drug involvement when a teenager, or 8 years ago ‘concerns about domestic violence/substance abuse/etc’)</td>
<td></td>
</tr>
<tr>
<td>- Mentions where there is NO timeframe, only ONE mention</td>
<td></td>
</tr>
<tr>
<td>(or one source) and NO inferences</td>
<td></td>
</tr>
<tr>
<td>- Mental Health is NONE if only cognitive or intellectual problems. Need to be <strong>psychopathology</strong>.</td>
<td></td>
</tr>
<tr>
<td>- Mentions with no specific times or incident examples.</td>
<td></td>
</tr>
<tr>
<td>- Time element would help make something low level – not current and no inference of its continuing impact</td>
<td></td>
</tr>
<tr>
<td>- Someone else’s concerns and no timeframe</td>
<td></td>
</tr>
<tr>
<td>- If more than 5 years ago, even if severe</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Salience Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>A medium level coding reflects one or more of these:</td>
<td>Medium-level 2</td>
</tr>
<tr>
<td>- Other person’s comments, unsubstantiated about the parent’s SA or DV (these can include DHS worker’s informal report)</td>
<td></td>
</tr>
<tr>
<td>- Self-report or other person’s report about history of the problem, but not as current – (these can include DHS worker’s informal report), ‘past’ indicates more then a year without any of the problems, even if the problem has been SEVERE.</td>
<td></td>
</tr>
<tr>
<td>- DHS report with no further evidence – as a quote (e.g., DHS report says …)</td>
<td></td>
</tr>
<tr>
<td>- The clinician makes an inference that the problem is not impacting greatly on the children or the family (e.g., although he is drinking quite a bit, he loves the children and is caring; even when dad is smoking cannabis daily, he is attached to the children and should not be separated from them;</td>
<td></td>
</tr>
</tbody>
</table>
A severe, high level coding reflects one or more of these:

- Self report of a severe event or involvement in the problem, usually currently or recent (e.g., I drink heavily every night, I hurt myself that day last month)
- Clinicians’ inference that the problem is ‘concerning’
- Official medical report (e.g., blood levels, urine tests, medication – anti-psychotic, unless more than 1 year ago)
- Increase of the problem recently or currently (e.g., she hits the child more now)
- Severe indication of the problem (e.g., she is always or mostly drug affected)
- Impact of the problem is severe or far-reaching (e.g., the child roam the streets while the parents are drinking, or fighting)
- Any court orders or convictions due to the problem, if in the last year
- If there’s a recommendation of an intervention about the problem
- If inconsistent evidence of any of the above, then mark ‘Medium’ level. If there is more sources that say ‘High’ than other, then put high, but if equal, then put the lower option (e.g. allegations of domestic violence or illegal substance abuse from different sources, code what the majority of the sources say)
- If severe incident is more than 5 years ago, then ‘Medium’ level coding

Cohen’s Kappas for three types of parent problems between two coders for 45 reports:

Father’s Domestic Violence: Agreement = 95%; $k = 0.83$; $SE = 0.09$
Father’s Substance Abuse: Agreement = 90%; $k = 0.80$; $SE = 0.08$
Father’s Mental Health Problems: Agreement = 82%; $k = 0.74$; $SE = 0.10$
Mother’s Domestic Violence: Agreement = 83%; $k = 0.76$; $SE = 0.11$
Mother’s Substance Abuse: Agreement = 85%; $k = 0.77$; $SE = 0.11$
Mother’s Mental Health Problems: Agreement = 90%; $k = 0.79$; $SE = 0.10$

(NB: The combined interjudge-reliability for the three levels of six parent problems in the 45 reports was sufficiently high, $k = 0.78$, $SE = 0.10$)
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