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Single Case Studies Can Improve Assessment and Therapy for Parenting of Vulnerable Children: A Review of Issues

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ABSTRACT

Commentators note difficulties in assessing and treating families where a parent has an episodic mental illness and where their parenting practices do not adequately meet the needs of their child, introducing a risk that child could develop a mental disorder. These parents are often assessed by non-clinicians as presenting with multiple and complex needs. As current universal therapeutic interventions have limited efficacy with these clients, some policy makers favour removal of vulnerable children from parental care and placing a child into child welfare care to reduce risk that child will be maltreated. This article provides an oversight of traditional and emerging practices in Australia to manage families who provide inadequate parenting, based on a review of literature. The review finds a lack of consistency in approach between disciplines involved in protection of children and recommends use of a more collaborative approach between disciplines. Topics where single case studies can improve practices and produce better outcomes for vulnerable children are highlighted. Criteria are proposed for single case studies that are relevant in improving service systems.

Keywords: Vulnerable Children, Multiple and Complex Needs, Parental Mental Illness, Objective Assessment, Targeted Intervention, Inter-Disciplinary, Categories of Parenting, Cumulative Harm

ABBREVIATIONS

COPMI: Children of Parents with a Mental Illness; DCP: Department for Child Protection; WHO: World Health Organisation.

INTRODUCTION

Researchers struggle to study families where children of parent with a mental illness are vulnerable as there are fears a child will have an increased likelihood of being maltreated. A review of literature finds these families are often viewed as having multiple and complex needs. The article proposes that a series of relevant single case studies can provide insight into complex family issues that are not responsive to standard therapies and universal interventions. Single case studies can identify assessment instruments that simplify complex issues and that lead to interventions that are effective in managing complex issues. The paper proposes that validated assessment instruments can identify specific topics where interventions are required, can facilitate delivery of targeted services to families where children are vulnerable, can improve parenting practices, and can reduce mental disorders in children.

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METHOD

This article uses a selective review of literature about how inadequate parenting practices associated with modifiable risk factors contribute to poor mental health in a child who is exposed to maltreatment.

International concern

A report by the World Health Organization (WHO) found that maltreatment of children is a global problem [1]. The WHO report found that only a fraction of children who experience maltreatment receive support from health professionals, despite the availability of effective prevention programs. The report also found that children who have been abused are more likely to abuse others when they become an adult, resulting in inter-personal violence being passed between generations. WHO reported that researchers consider child maltreatment to be a complex problem that is difficult to study [2].

One traditional solution for children assessed as being at risk of maltreatment is to remove the child from parental care and to place the child into foster care. However, studies find that simply placing a child into home-based foster care does not improve a child's mental health [3]. Further, a review of evidence about efficacy of parenting interventions to reduce child maltreatment failed to identify any universal interventions with established efficacy [4].

The Australian Government introduced a National Children's Mental Health and Wellbeing Strategy 2021 that identified cohorts of children with increased risk of developing a mental disorder who require better access to targeted therapy supports [5]. Two cohorts of vulnerable children identified in the National Strategy are children whose parent has a mental illness (COPMI children), and children involved with child welfare authorities.

Children referred to a child protection authority become involved in a multi-disciplinary system. Arguably, a distinctive approach is required to assist children in a multi-disciplinary system. Introduction of an objective assessment instrument that is understood by the key disciplines will enhance coordination and collaboration in an inter-disciplinary system of care. It is proposed that key disciplines involved in the wellbeing of vulnerable children include general health disciplines, mental health disciplines, child protection disciplines, and the legal discipline. To collaborate, these key disciplines need to agree about psycho-legal concepts used in the field of child maltreatment including about relevant assessments and effective interventions.

This article proposes that the task of assessing and treating childhood maltreatment can be facilitated by publication of single case studies that address key topics, and that are understood by participating disciplines.

Legal obligations

One reason that treatment of child maltreatment is complex is that effective work needs to be inter-disciplinary. Legislation has been passed in some jurisdictions that obliges health professionals who suspect a child is exposed to maltreatment to make a mandatory notification to a child welfare department that is authorised to investigate risk of harm to the child. However, legislation that mandates notification might not obligate the health practitioner to refer a vulnerable family for early intervention therapy and supports. Legislation that mandates only notification arguably produces an unbalanced obligation on health professionals that can result in a vulnerable family being subjected to forensic investigations that might involve removal of a child from parental care while an investigation is conducted, without ensuring the family first receives appropriate early intervention therapy [6].

One paper co-authored by 70 researchers of attachment theory reported that removing children from parental care is a traumatic experience for children, with authors recommending that ongoing separation of a child from attachment figures be used as a method of last resort following delivery of early therapeutic interventions [7]. Other writers note that delivery of targeted interventions for vulnerable families is enhanced by use of validated instruments that provide objective assessments of vulnerable families by focusing on modifiable risk factors that can be changed using therapies that are evidence-based and innovative [8].

Legal standards for an expert witness

Following introduction of a National Children's Mental Health and Wellbeing Strategy, mental health clinicians in Australia are encouraged to provide therapy for vulnerable families that is reportable to a court that makes decisions about a family [5]. Health clinicians who provide reportable therapy need to understand three legal concepts: role of an expert witness; standards of proof required in a family-oriented court; and criteria for admissibility of expert evidence.

Role of an expert witness

An expert witness has specialised knowledge about a topic that is outside the ordinary experience of a tribunal/court, where their expert knowledge was acquired by their training, study or experience. The role of an expert witness in Australia is to provide evidence that is within their area of expertise, is relevant to issues in dispute, and is impartial. Experts are cautioned not to become an advocate who supports the cause of one party in a dispute, including a person for whom they provided therapy and who might have requested a treatment report [9]. Courts note it is the role of a lawyer to advocate on behalf of their client, not the role of a therapist.

An expert witness is permitted to express an opinion about a topic that is disputed between parties. Before expressing an opinion, an expert must make observations about factual matters, and must explain the reasoning process they used when they applied their specialist knowledge and drew a conclusion and expressed an opinion.

A therapist / clinician is permitted to provide expert opinion in an Australian family-oriented court. Evidence submitted by a clinician will be viewed as being impartial if it is based on use of objective assessment methods. However, evidence from a therapist will not be viewed as being independent of the party they treated. A court may give less weight to evidence provided by a clinician if the court considers the clinician's evidence favours their client and shows a "therapist's bias."

Standard of proof

Courts in Australia distinguish between the standard of proof used in criminal courts which is 'beyond reasonable doubt,' and the standard of proof used in civil courts which is 'on the balance of probabilities.' Both family law courts and child protection courts are civil courts that apply the standard 'on the balance of probabilities.'

Criteria for admissibility of evidence

The admissibility of evidence presented by expert witnesses in Australia is evaluated using two sets of criteria; Daubert criteria and Makita criteria.

The Daubert criteria can be summarised as: is an assessment technique or theory testable; has the test been subjected to peer review and publication; is information available about the error rate of predictions made by the test; and has a test attracted widespread acceptance within a relevant scientific community [10].

Australian courts have adopted criteria from a Makita case that include: an opinion proffered by an expert must be wholly or substantially based on the witness' expert knowledge; observations must be identified and admissibly proven by the expert; an opinion based on 'assumed' or 'accepted' facts must be identified and proven in some other way; and an opinion of an expert requires demonstration or examination of the scientific or intellectual basis of the conclusions reached [10].

This article proposes that single case studies can provide information about assessment methods that are objective and meet legal standards of being admissible as evidence in the complex field of minimising maltreatment of children.

Current policies and practices

This section discusses policy frameworks used in Australia to manage families where children are at increased risk of maltreatment and of developing a mental disorder.

Australia has a federal system of government, where the National Government passes family law legislation governing management of disputes between separated parents, and State Governments pass child protection legislation governing disputes between parents and a DCP. Australia researchers have reported that issues of parental mental illness, domestic violence, substance misuse, and difficulty in managing children's behaviour are addressed in both family law courts and child protection courts [11,12].

Framework for interventions

The Australian Government adopted a National Framework for Protecting Australia's Children 2009 that identifies four categories of parenting for policy purposes [13]. The categories of parenting can be para-phrased: competent parents are eligible to receive universal prevention programs; vulnerable families receive targeted early intervention services; at-risk families receive targeted rehabilitation services; and access that unfit parents have with their child is restricted by a statutory system.

The four categories of parenting might be further defined as follows. Universal prevention programs apply to the whole population and can be delivered through mass media and through groups. Targeted early intervention services are available for families who present with specific risk factors but where no harm has yet occurred. Targeted rehabilitation programs are individualised interventions provided when there is evidence that a child has experienced some harm, or where a number of risk factors are identified introducing a risk of cumulative harm over time. Both early intervention and rehabilitation services are provided while a family is intact or during a reunification process, and therapies are delivered by a clinician with skills relevant to each risk factor who operates using a trans-diagnostic approach [14]. A clinician who provides early intervention and rehabilitation services might be asked to report therapy to an authority who made a referral. Two types of legal restrictions on access to a child might be imposed on a parent. Restricted access occurs when an order limits contact between a parent and child, perhaps permitting supervised contact. Prohibited contact occurs when there is a legal order that it is unsafe for a child to have any contact with their parent as a child has been exposed to unacceptable harm.

The framework above requires clarification of criteria to distinguish each type of service. It is proposed that two levels of intervention (early intervention therapy and rehabilitation) can be provided by a health professional, simultaneously with a notification to a child welfare authority. Two types of intervention require involvement of a court: restricted access and prohibited contact.

It is hypothesised that publication of relevant single case studies can assist in clarifying criteria to define the proposed categories of parenting for child custody and child protection purposes.

Child welfare practices in Australia

Practices used by Departments of Child Protection (DCP) in Australia have recently been documented. Writers note that child welfare policies prioritise protection of children from risk of harm over providing early intervention therapies [15]. Two approaches for assessing risk of future harm to children have been proposed, where one approach examines whether actual harm to a child has been substantiated, and a second approach examines whether a child is exposed to risk factors shown in research to be associated with an increased risk of harm to children [16].

Researchers have classified types of risk factor. One framework distinguishes between risk factors that occur at a broad social and community level and risk factors that occur at an individual / family level [17]. Social and community factors include availability of adequate housing, income support, cultural norms encouraging prosocial behaviour, and availability of intervention programs for families whose parenting practices are inadequate [18].

Writers report that investigating authorities usually focus on risk factors at the family and individual levels [19]. Unfortunately, Australian writers report that no progress has been made in identifying a best practice instrument for assessing risk of future maltreatment of children for use by child welfare agencies [20,21].

A policy emphasis on preventing harm to a child can result in a DCP applying to court for an order to remove a child from parental care while they conduct investigations [19]. Writers note that, despite evidence that removing a child from parental care is itself traumatic for children [7], the risk to children of removing them from parental care is often not emphasised by DCP in their submissions to court [6]. Auditors report that most funding allocated to DCPs in Australia is used to place children into out-of-home care rather than to support parents to improve their inadequate parenting practices by providing early intervention services [19].

Reports indicate that welfare authorities commonly assess notified families who present with several risk factors as having 'multiple and complex needs' [21]. Families identified as having multiple and complex needs might be referred to a wrap-around service that is funded by DCP to provide intensive family support using universal interventions rather than specific interventions that target identified needs of each family [22].

Swain and Camerson reviewed case files of parents with a disability who were involved in legal proceedings in the state of Victoria Australia and found no evidence that many notified parents had been referred to relevant support services [23]. Further, the Office of Public Advocate in Victoria Australia reported that, once a family had been referred to DCP, support services were often withdrawn as the department moved its focus away from supporting the family to conducting forensic investigations to substantiate allegations, even when the stated goal of intervention was to reunify children with their family [24]. The report stated that, once DCP removes a child from parental care to investigate a family, DCP often restricts the child's contact with their parent to a few hours per week of supervised contact. The practice of restricting contact occurs despite information that markedly restricting a child's contact with their parent increases likelihood that the child's bond with their parent will be disrupted, and a child is likely to develop an attachment disorder [24].

Australian researchers report that parents with a mental health diagnosis comprise 21.8% of child protection cases [25], and if a parent has been diagnosed with a mental disorder, then there is an increased likelihood the family will be referred to a DCP for investigation [25]. One study found that, of parents with a disability who appeared before a child protection court, the parental disability was attributed to a mental disorder in 88% of cases [23]. A study from New South Wales in Australia found that children whose parent had a mental illness were six times more likely to be referred to DCP and to be placed in out-of-home care [26,27]. A study in Western Australia found that 10% of mothers with a documented mental health diagnosis became involved in the child welfare system, and that almost half of children in the child protection system had a mother with a mental health record [28].

Another risk factor involves a child being exposed to family violence or to emotional abuse. Australian writers report cases where women who approached welfare authorities seeking assistance regarding family violence did not receive support to leave their abusive partner, but instead had their child removed from their care as the mother was accused of

failing to protect their child from the abusive parent [29]. In some cases, mothers with a mental disorder who alleged domestic violence were reportedly disbelieved and their child was placed with the allegedly abusive parent [30].

A further complicating factor is that, in some cases, mothers with a mental illness used illicit substances as a temporary method to cope with their distress. A study in San Francisco found that 8% of parents involved with child protection services had only mental health disorder, and 10% had comorbid mental health and substance misuse disorders [31]. A determination that a child was unsafe was ten times more likely when their mother had comorbid conditions.

One more issue is that, although Article 12 of the United Nations Convention on the Rights of the Child emphasises that children should be consulted about matters that affect them, the principle of consulting children is reportedly often not adhered to by child welfare authorities [32]. Australian case law recognises a concept of a 'mature minor' who is capable of making their own decisions [33]. One reason children are not consulted when an order is sought to remove the child from parental care involves a lack of clarity in legislation about the age or qualities required for a young person to be viewed as being a mature minor [33,34].

This article proposes that single case studies can document good practices to manage risk of harm to children in vulnerable families.

It is possible that, due to the number of risk factors identified in research, there will be a need to develop specific interventions to manage each type of risk. Single case studies can contribute to the development of risk assessment tools that lead to identification of therapies that focus on addressing specific risk factors.

Measuring risk factors

It appears beneficial to introduce an assessment instrument that can be used to screen families and to classify families objectively into risk categories, as proposed in Australia's National Framework for Protecting Children [13].

An assessment instrument could list individual factors that are assessed on a continuum as being either a risk factor or a protective factor, enabling assessors to record how a parent functions on each factor. Some writers criticise the approach of assessing a list of factors as contributing to a 'deficit' view of parenting, and as implying that parents need to achieve a standard where they display no faults and they function at a near-perfect level rather than provide parenting that meets a criterion of being adequate / good-enough in meeting their child's needs [19]. Assessors who use instruments that list modifiable factors respond to the criticism that lists highlight deficits by noting that an approach that assesses all risk factors has benefits of: identifies specific topics where a parent requires assistance and encourages delivery of supports for vulnerable families: recognises strengths; facilitates delivery of early interventions that target identified shortcomings; identifies families where children are at risk of cumulative harm; contributes to setting thresholds that distinguish categories of parenting, and minimises unnecessary removal of children from parental care; and functions as an outcome measure of efficacy of interventions [8].

Indicators of potential harm to a child

Current research identifies several discrete risk factors for maltreatment of children and finds that risk factors can cluster [35]. Risk factors that occur at a parental and family level, and that are modifiable by targeted interventions, have been identified by the WHO and other bodies to include: parent has a mental disorder; separation of parents; domestic violence; parent misuses substances; parent has difficulty bonding with their infant; parent was maltreated themselves as a child and has an inadequate parenting template; parent does not manage their budget; and parent is isolated and lacks social support [1,2].

It appears likely that distinctive interventions will be required to address each set of risk factors. It appears best to arrange for specialised interventions to be delivered by practitioners who have adequate skills to address each set of risk factors.

Parents with mental illness

This article focuses on parents who have a diagnosed mental illness and have experienced an episode of illness. It is proposed that the risk factor of parental mental illness (including impacts on a child) is best addressed by a mental health service. Several studies have reported that children whose parent has a mental illness (COPMI children) are at a heightened risk of themselves developing a mental disorder unless targeted prevention programs are provided [36,37]. Tustin reviewed literature about distinct inadequate parenting practices that occur more often in parents diagnosed with depression, anxiety, and a mood or personality disorder [38]. It is proposed that: parenting practices used by parents with a mental health diagnosis can be improved by using interventions that focus on parent-child interactions; many parents can reach a standard of adequate parenting; and new methods of intervention can be reported in single case studies. Interventions that are effective in producing long-term improvements in parenting practices can be identified initially from single case studies.

This article proposes that single case studies can report the viability of delivering early intervention and rehabilitation therapies that are targeted to address combinations of risk

issues posed by parents who have experienced an episode of mental illness and who have comorbid conditions of: exposure to domestic violence; misuse of substances; and temporary use of inadequate parenting practices during an episode of illness. Interventions for a parent can include learning to self-manage their mental illness [39]. A child who has been exposed to these circumstances is likely to experience trauma, and to display disturbed behaviours that their parent finds difficult to manage. Arguably, the most appropriate intervention in these cases provides joint parent-child therapy that addresses interactions between the parent-child dyad.

RESULTS

The review of literature indicates that families where a parent has a mental illness present as having many complex needs, and their children are at increased risk of developing a mental disorder due to inadequate parenting practices. The review identified a range of issues where it is plausible that targeted therapies can be developed and provided to vulnerable families to improve parenting practices and to improve the mental wellbeing of children in the families. It appears plausible to introduce a range of therapies while children live with their parents, before placing a child into long-term out-of-home care. It is proposed that specific needs of families with multiple and complex needs can be identified using an objective instrument that screen for specific risk factors.

CONCLUSIONS

This article reviews a range of issues associated with families where a parent has a mental illness and is viewed as having multiple and complex needs, resulting in their children being at increased risk of developing a mental disorder. The article proposes that issues arising in these families can be identified and managed using a screen instrument that identifies specific modifiable risk factors in each family, where the instrument is used to refer vulnerable families to early intervention therapies.

The article proposes that significant progress can be made by encouraging publication of single case studies about relevant issues.

One topic for authors who write single case studies involves the standard of information required by a publisher. This article proposes that the aims of single case studies involving vulnerable children are to improve assessment procedures, and to identify interventions that are effective in distinct circumstances.

Single case studies might be reported by a health provider or by a user of health services.

Criteria for how social and behavioural scientists might report single case studies about managing children's behaviour were discussed by Barlow and Hersen [40]. This article suggests that distinct criteria are required for the assessment and treatment of vulnerable families as follows.

Authors should provide sufficient data about a family context for readers to replicate the study. Contextual data includes information about family composition, any diagnoses, parental and children's behaviours of concern, measures used, information from pre-tests and post-tests, and conclusions drawn from the study. As effective interventions often change interactions between a parent and child, measures may be required of behaviours of both participants in an intervention.

Information should be provided about number of sessions provided, resources used, whether sessions occur in-home or in a clinic, qualifications of providers, and level of efficacy.

If an intervention is derived from an evidence-based theory, then relevant theoretical principles can be summarised. It is recommended that authors name innovative interventions to facilitate replications.

Single case designs usually compare a pre-test and a post-test score using a measure that can be validated and replicated. Suitable measures are the frequency of defined behaviours, and the likelihood that a parent and child behave in specific ways in defined situations. A study might use a checklist of items that has potential to be developed into a validated assessment instrument if the checklist is used with a sufficiently large sample of similar clients, enabling data to be analysed using psychometric procedures.

Studies can include families where both a parent and a child are diagnosed with mental health conditions, and where joint interventions involving both family members are provided by a coordinated team [41].

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CONFLICTS OF INTEREST

The author does not identify any conflicts of interest.

REFERENCES

1. World Health Organisation. (2022). Child maltreatment. Available at: www.who.int/news-room/fact-sheets/detail/child-maltreatment
2. Fegert JM, Stötzel M. (2016). Child protection: a universal concern and a permanent challenge in the field of child and adolescent mental health. Child Adolesc Psychiatry Ment Health. 10:18.

3. Sawyer MG, Carbone JA, Searle AK, Robinson P. (2007). The mental health and wellbeing of children and adolescents in home-based foster care. Med J Aust. 186(4):181-184.

4. Whitcombe-Dobbs S, Tarren-Sweeney M. (2019). What evidence is there that parenting interventions reduce child abuse and neglect among maltreating families? A systematic review. Developmental Child Welfare. 1(4):374-393.

5. National Children's Mental Health and Wellbeing Strategy. (2021). Australian Government. Available at: www.mentalhealthcommission.gov.au

6. Trivedi S. (2019). The harm of child removal. New York University Review of Law and Social Change. 523.

7. Forslund T, Granqvist P, van IJzendoorn MH, Sagi-Schwartz A, Glaser D, Steele M, et al. (2022). Attachment goes to court: child protection and custody issues. Attach Hum Dev. 24(1):1-52.

8. Tustin D, Whitcombe-Dobbs S. Parenting capacity instrument for child protection. In D. Tustin (Ed.), Psycho-legal concepts for parenting in child custody and child protection volume 3 - Structured instruments to provide objective assessments in court-related family work. In press. Springer Nature.

9. Expert Evidence Practice Note (GPN-EXPT) 2016.

10. Australian Law Reform Commission. (2010). Uniform Evidence Law, ALRC report 102.

11. Higgins DJ, Kaspiew R. (2008). 'Mind the gap…': Protecting children in family law cases. Australian Journal of Family Law. 22(3):235-258.

12. Higgins D, Kaspiew R. (2011). Child protection and family law ... Joining the dots. (NCPC Issues No. 34). Melbourne: National Child Protection Clearinghouse at the Australian Institute of Family Studies.

13. National Framework for Protecting Australia's Children 2009 can be accessed at: Australian Government, Department of Social Services. http://www.fahcsia.gov.au/sa/families/pubs/framework_protecting_children/Documents/child_protection_framework.pdf

    http://www.coag.gov.au/coag_meeting_outcomes/2009-04-30/docs/child_protection_framework.pdf

14. Barlow DH, Farchione TJ, Bullis JR, Gallagher MW, Murray-Latin H, Sauer-Zavala S, et al. (2017). The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders Compared With Diagnosis-Specific Protocols for Anxiety Disorders: A Randomized Clinical Trial. JAMA Psychiatry. 74(9):875-884.

15. Beckett H, Warrington C. (2024). 'Do no harm'? Rethinking risk and harm narratives in abuse-focused research with children. Child Protection and Practice. 2:100037.

16. Hussey JM, Marshall JM, English DJ, Knight ED, Lau AS, Dubowitz H, et al. (2005). Defining maltreatment according to substantiation: distinction without a difference? Child Abuse Negl. 29(5):479-492.

17. Austin AE, Lesak AM, Shanahan ME. (2020). Risk and protective factors for child maltreatment: A review. Curr Epidemiol Rep. 7(4):334-342.

18. Younas F, Gutman LM. (2023). Parental Risk and Protective Factors in Child Maltreatment: A Systematic Review of the Evidence. Trauma Violence Abuse. 24(5):3697-3714.

19. Libesman T, Gray P, Chandler E, Briskman L, Didi A, Avery S. (2023). Parents with disability and their experiences in child protection systems. Royal Commission into Violence, Abuse, Neglect and Exploitation of people with disability. Australia. Available at: https://apo.org.au/sites/default/files/resource-files/2023-07/apo-nid323482.pdf

20. White A, Walsh P. (2006). Risk assessment in child welfare. Centre for Parenting and Research, NSW Department of Community Services, Australia.

21. Gartoulla P, Butler K. (2024). Risk assessment approaches in child protection. Australian Institute of Family Studies. Australia.

22. Olson JR, Benjamin PH, Azman AA, Kellogg MA, Pullmann MD, Suter JC, et al. (2021). Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents. J Am Acad Child Adolesc Psychiatry. 60(11):1353-1366.

23. Swain P, Cameron N. (2003). Good enough parenting: Parental disability and child protection. Disability & Society. 18(2):165-177.

24. Carter B. (2015). Rebuilding the village: Supporting families where a parent has a disability – Report 2: Child protection. Office of the Public Advocate. p. 13.

25. Llewellyn G, McConnell D, Ferronato L. (2003). Prevalence and outcomes for parents with disabilities and their children in an Australian court sample. Child Abuse Negl. 27(3):235-251.

26. Sheehan R, Levine G. (2005). Parents with mental illness: Decision-making in Australian Children's Court cases involving parents with mental health problems. Journal of Social Welfare and Family Law. 27(1):17-30.

27. Green MJ, Kariuki M, Chilvers M, Butler M, Katz I, Burke S, et al. (2019). Inter-agency indicators of out-of-home-care placement by age 13-14 years: A population record linkage study. Child Abuse Negl. 93:91-102.

28. O'Donnell M, Maclean MJ, Sims S, Morgan VA, Leonard H, Stanley FJ. (2015). Maternal mental health and risk of child protection involvement: mental health diagnoses associated with increased risk. J Epidemiol Community Health. 69(12):1175-1183.

29. Woodlock D, Western D, Bailey P. (2014). Voices against violence. Paper 6: Raising our voices – Hearing from women with disabilities, Report, Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre Victoria. pp. 44, 45, 49.

30. Carter B. (2015). Rebuilding the village: Supporting families where a parent has a disability – Report 2: Child protection, Report, Office of the Public Advocate. p 36.

31. Roscoe JN, Lery B, Chambers JE. (2018). Understanding child protection decisions involving parents with mental illness and substance abuse. Child Abuse Negl. 81:235-248.

32. Beckett H, Warrington C. (2024). 'Do no harm'? Rethinking risk and harm narratives in abuse-focused research with children. Child Protection & Practice. 2:100037.

33. Bird S. (2011). Consent to medical treatment: the mature minor. Aust Fam Physician. 40(3):159-160.

34. Tustin D. (2024). Hearing the Voice of a Child and Thresholds for Making Legal Decisions. In: Tustin D. (eds) Psycho-Legal Concepts for Parenting in Child Custody and Child Protection Vol. 3. Springer, Singapore.

35. Rijbroek B, Strating MMH, Konijn HW, Huijsman R. (2019). Child protection cases, one size fits all? Cluster analyses of risk and protective factors. Child Abuse Negl. 95:104068.

36. Reupert AE, Maybery D, Nicholson J, Gopfert M, Seeman M. (2015). Parental psychiatric disorder: Distressed parents and their families (3rd ed.). London, England: Cambridge University Press.

37. Maybery DJ, Reupert AE, Patrick K, Goodyear M, Crase L. (2019). Prevalence of parental mental illness in Australian families. Psychiatric Bulletin. 33(1):22-26.

38. Tustin D. Parenting practices associated with specific parental mental illnesses. In D. Tustin (Ed), Therapy interventions for vulnerable families, vol 4; Psycho-legal concepts for parenting in child custody and child protection. In press. Springer Nature.

39. Tustin D. Example of self-management of a mental illness. In: Tustin D (Ed), Therapy interventions for vulnerable families, vol 4; Psycho-legal concepts for parenting in child custody and child protection. In press. Springer Nature.

40. Barlow DH, Hersen M. (1984). Single-case experimental designs: Strategies for studying behavior change (2nd ed.). New York: Pergamon Press.

41. Vidair HB, Reyes JA, Shen S, Parrilla-Escobar MA, Heleniak CM, Hollin IL, et al. (2011). Screening parents during child evaluations: exploring parent and child psychopathology in the same clinic. J Am Acad Child Adolesc Psychiatry. 50(5):441-450.