Submission to the Royal Commission into Family Violence

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Centre for Excellence
in Child and Family Welfare Inc.

CONTENTS

INTRODUCTION - THE CENTRE FOR EXCELLENCE IN CHILD AND FAMILY WELFARE

The Centre for Excellence in Child and Family Welfare ('the Centre') is the peak body for child and family welfare in Victoria, providing independent analysis, dialogue and cross-sectoral engagement to address factors that perpetuate disadvantage and vulnerability. Working alongside our 90 member organisations, the role of the Centre is to build capacity through research, evidence and innovation to influence change. The Centre and its member organisations collectively represent a range of early childhood, child, youth and family support services, and out of home care services, including kinship care, foster care and residential care.

The objects of the Centre include:

- To contribute to the wellbeing of children and young people and the support and strengthening of family life particularly where there is poverty and disadvantage.
- To promote leadership and excellence in child, youth and family services.
- To actively represent the interests of members to government and to the community, and to influence community expectations of support available to children and families.
- To develop and influence policies in child, youth and family welfare, including providing policy advice to government in respect of child, youth and family welfare.
- To promote ongoing research and evaluation in child, youth and family welfare

ROYAL COMMISSION INTO FAMILY VIOLENCE

The Centre is committed to the work of the Royal Commission into Family Violence. To support our input into the Royal Commission the Centre conducted a survey of Child and Family Services Alliances seeking data and information regarding family violence. The Child and Family Services Alliances operate as a governance and oversight group for Child FIRST and Integrated Family Services in 24 catchments across the State. The Centre also had a series of discussions with our members and participated in a number of forums and roundtables to inform the content of this submission.

We have also endeavoured to source recent Victorian data relating to family violence and its intersection with services our members provide.

Our primary focus in this submission is on the impact of family violence upon children. The second half of the submission addresses a number of questions posed by the Royal Commission's *Issues Paper.*[1]

The Centre submits this submission in the hope that it will make a useful contribution to the deliberations of the Royal Commission.

[1] Royal Commission into Family Violence, *Issues Paper*, March 2015

WHAT IMPACT DOES FAMILY VIOLENCE HAVE UPON CHILDREN?

A number of research articles, meta-analyses and literature reviews have examined the specific impact of family violence on children. A small representative selection of these studies is summarised in Table One below:

TABLE ONE: META-ANALYSES AND LITERATURE REVIEWS ON THE IMPACT OF FAMILY VIOLENCE UPON CHILDREN

Author(s), Title, Journal	Key findings
Kitzman, KM., Gaylord, NK., Holt, AR and Kenny, ED. *Child Witness to Domestic Violence: A Meta-analytic Review*, Journal of Consulting and Clinical Psychology, 2003, Vol 71, No 2	• Examined 118 studies of the psycho-social outcome of children exposed to inter-parental violence • Correlation studies showed a significant association between exposure and child problems • Study provided *"robust evidence that exposure to interparental aggression is associated with significant disruptions in children's psycho-social functioning, at least in the short term."*(p.347) • Child witnesses had significantly worse outcomes relative to non-witnesses
Sternberg, KJ., Lamb, ME., Greenbaum, C., Cicchett, D., Dawud, S., Cortes, RM., Krispin, O and Lorey, F. *Effects of Domestic Violence on Children's Behavior Problems and Depression,* Developmental Psychology, 1993, Vol 29, No. 1, 44-52	• Surveys of the parents and children (involving 118 children) involved with Israeli social services were self-administered and analysed to assess the effects of various types of family violence on children's behaviour problems and depression. 33 of the children had been physically abused by their parents, 16 had witnessed spouse abuse, 30 had been both victims and witnesses of family violence and 31 had experienced no known family violence. • Victims and abused witnesses were more likely than the comparison group to report depressive symptoms as well as internalising and externalising behaviour problems
Wolfe, DA., Crooks, CV., Lee, V., McIntyre-Smith, A and Jaffe, PG. *The Effects of Children's Exposure to Domestic Violence: A Meta-Analysis and Critique,* Clinical Child and Family Psychology Review, Vol 6, No. 3, September 2003	• Examined 41 studies on child development outcomes when compromised by exposure to family violence. • 40 of the studies indicated that exposure to family violence was associated with emotional and behaviour problems. • Co-occurrence of child abuse increased the level of emotional and behavioural problems
Hamby, S., Finkelhor, D., Turner, H., and Ormrod, R., *Children's Exposure to Intimate Partner Violence and Other Family Violence*, US Department of Justice, 2011	• National survey of 4,949 American children exploring their exposure to intimate partner violence (IPV) • 11.1 per cent of survey children found to be exposed to some form of IPV in the preceding year and 25.6 per cent exposed to some form of IPV during their lifetime • 6.6 per cent found to be exposed to physical IPV (eye-witness to assault of parent, pushed, hit or slapped, and severe physical assault (kicked, choked or beat up)) in preceding year and 17.9 per cent during their lifetime • 1.3 per cent of survey children witnessed a parent subject to severe physical assault in the preceding year and 5.3 per cent during their lifetime

There is very limited, contemporary, publicly available data available on the impact of family violence on Victorian children. However some useful data from the late 1990s provides a historical snapshot of the impact of family violence on vulnerable children involved with Victoria's statutory child protection service. In 2002 the then Victorian Department of Human Services released a report[2] on child protection and placement services, which included a chapter on the characteristics of children and young people involved with statutory child protection services. Table Two[3] from this report describes a set of parental characteristics associated with children subject to a substantiated finding of abuse and neglect in the period between 1996 and 2001. The parental characteristics were: Psychiatric Disability, Intellectual Disability, Physical Disability, Family Violence, Alcohol Abuse and Substance Abuse.

[2] Department of Human Services, *An Integrated Strategy for Child Protection and Placement Services*, 2002

[3] ibid. p.27

TABLE TWO: SUBSTANTIATED CHILD ABUSE AND NEGLECT CASES: TYPE OF PARENTAL CHARACTERISTICS RECORDED, VICTORIA, 1996–97 TO 2000–01: %

	Psychiatric Disability	Intellectual Disability	Physical Disability	Family Violence	Alcohol Abuse	Substance Abuse
1996-97	12	2	3	38	24	21
1997-98	16	4	4	47	31	31
1998-99	17	3	4	50	31	31
1999-00	19	3	5	50	31	31
2000-01	19	3	4	52	31	33

Notes: The rows sum to more than 100 per cent as parents can be recorded as having more than one characteristic.
Source: *Department of Human Services*

Family violence is the parental characteristics most frequently associated with substantiated child abuse and neglect, occurring in 52 per cent of cases in 2000-01.

A more recent examination of substantiated cases of child protection from the years 2001-2005 revealed that there was a carer history of domestic violence in 53% of the cases sampled (n=38,487).[4]

There would be considerable merit in updating this data to provide evidence of trends that can inform appropriate policy responses. The routine collection of the data described in the preceding table ceased in the mid-2000s but the Centre understands its collection may have been recently reintroduced by the Department of Health and Human Services.

The Department of Health and Human Services *Child Development and Trauma Guide* provides a comprehensive guide to the impact of trauma, including family violence, on children.[5] This guide is now in widespread use in the child and family services sector in Victoria, in other Australian jurisdictions and in many overseas jurisdictions.

Trauma and its impact is considered across seven age cohorts:

- 0-12 months
- 12 months – 3 years
- 3 to 5 years
- 5 - 7 years
- 7 – 9 years
- 9 – 12 years
- 12- 18 years

For a very young child, aged 0-12 months, the guide provides the following advice on the possible impact of trauma:

- neurobiology of brain and central nervous system altered by switched on alarm response
- behavioural changes
- regression in recently acquired developmental gains
- hyper-arousal, hypervigilance and hyperactivity
- sleep disruption
- loss of acquired motor skills
- lowered stress threshold
- lowered immune system
- fear response to reminders of trauma
- mood and personality changes
- loss of, or reduced capacity to attune with caregiver

[4] Laslett, A. M., 2013, *Alcohol and child maltreatment in Australia through the windows of child protection and a national survey*. PhD Thesis by research, The University of Melbourne, Melbourne, in Laslett, Ann- Marie et al., *The hidden harm: Alcohol's impact on children and young families*, Foundation for Alcohol Research and Education, 2015.

[5] Department of Human Services, *Child Development and Trauma Guide, 2007.* Accessed at: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/586167/child-development-and-trauma-guide-1_intro.pdf

- loss of, or reduced capacity to manage emotional states or self soothe
- insecure, anxious, or disorganised attachment behaviour
- heightened anxiety when separated from primary parent/carer
- indiscriminate relating
- reduced capacity to feel emotions - can appear 'numb'
- cognitive delays and memory difficulties
- loss of acquired communication skills[6]

For each age cohort, where trauma experience is indicated, the guide provides a series of child and family risk factors, parent risk factors and wider factors that indicate positive outcomes. A detailed description of typical developmental milestones is described, together with descriptions of behaviours that may indicate trauma and strategies practitioners can utilise to help parents and carers ameliorate trauma.

For example, for the parents or carers of a 0-12 month child that may have experienced significant trauma, the following advice is provided:

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves, to manage their own shock and emotional responses
- seek information and advice about the child's developmental progress
- maintain the child's routines around holding, sleeping and eating
- seek support (from partner, kin, Maternal and Child Health nurse) to understand, and respond to, infant's cues
- avoid unnecessary separations from important caregivers
- maintain a calm atmosphere in child's presence. Provide additional soothing activities
- avoid exposing child to reminders of trauma
- expect child's temporary regression; and clinginess - don't panic
- tolerate clinginess and independence
- take time out to recharge[7]

CUMULATIVE HARM

The *Children, Youth and Families Act 2005* included a requirement that practitioners working with vulnerable children must consider:

> *10 (3) e the effects of cumulative patterns of harm on a child's safety and development;*

The concept of cumulative harm is relatively recent, but now accepted as a critical consideration in work with vulnerable children. Cumulative harm refers to:

> *… the effects of patterns of circumstances and events in a child's life, which diminish a child's sense of safety, stability and wellbeing. Cumulative harm is the existence of compounded experiences of multiple episodes of abuse or 'layers' of neglect. The unremitting daily impact on the child can be profound and exponential, covering multiple dimensions of the child's life.*[8]

Cumulative Harm: a conceptual overview provides a detailed explanation of the impact of family violence on the developing child:

> *As referred to earlier in this paper, family violence is a common factor in the landscape of lives of children who experience cumulative harm. The presence of violence has a highly detrimental impact*

[6] Department of Health and Human Services, *Child development and trauma specialist practice resource: 0 – 12 months*. Accessed at: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0004/586174/child-development-trauma-0-12mths-2012.pdf

[7] ibid

[8] Department of Human Services, *Cumulative Harm: a Conceptual Overview,* 2008

on the developing child and a growing body of evidence has documented the particular vulnerability of infants. Alongside the act of physical violence, an additional element of intra-familial toxicity is emotional violence - humiliation, coercion, degradation, and the threat of abandonment or physical assault (Perry 2001).

> *Lack of critical early life nurturing, chaotic and cognitively impoverished environments, persisting fear and physical threat and, finally, watching the strongest, most violent in the home get what he wants, and seeing the same aggressive violent use of power idealised on television and at the movies...[t]hese [children] have been incubated in terror…waiting to be the one that controls, the one who takes, the one who hits, the one who can make the fear, not take the fear (Perry 1997, p.10).*

Humphries and Stanley (2006) refer to the direct and indirect ways parenting is affected by family violence. These include the high anxiety and depression which undermines a parent's ability to care for their children, and a preoccupation with trying to control the domestic environment so that the perpetrator's needs are prioritised whereby the children's needs for playing, attention and fun are not met, or are intermittently met. Physical incapacitation as a result of an assault leaves a carer unable to provide physical care, and belittlement and humiliation in front of a child undermines the authority needed to parent confidently. There is also a mismatch between a parent struggling with their survival, and a distressed child demonstrating emotional and behavioural difficulties, who needs more intensive parental involvement. Failing to leave the abusive relationship or returning to the violent relationship also undermines the parent-child relationship.

> *[9]... [I]t should not be assumed that the removal of the perpetrator is a 'quick fix' which will immediately remedy the problems. The withdrawal of professionals when it is assumed the child is safe sets the woman up to fail just at the time when she may be in a position to more easily avail herself and her children of help and support. Recovery processes entail assistance not just for the individual women and children, but for the relationship between them. This is an essential aspect of domestic violence intervention which has been marginalised through failures to conceptualise domestic violence as not only an attack on the survivor (usually the mother), but also an assault on her relationship with her children (Humphries & Stanley 2006, p.30).*

Recovery from trauma and cumulative harm is possible for most children provided the parents or carers are able to recognise the indicators, respond appropriately and if necessary, are supported early to obtain specialist help. This reinforces the importance of providing early assistance and support to families experiencing family violence. For parents exhibiting other risk factors, such as drug and alcohol misuse or mental health issues, early support is vital to address the parents' own support needs, their parenting needs and the needs of their children.

[9] ibid. p.30

FAMILY VIOLENCE: A CONCEPTUAL FRAMEWORK

Family Violence is broad, complex and multi-faceted. Therefore responding effectively to family violence requires an equally broad, complex and multi-faceted response. Reaching a level of agreement on the key components of effective responses to family violence will encourage the development of a shared consensus in the community and among service providers and help build the necessary momentum for reform and change.

The Centre's primary focus is on the safety and wellbeing of children and young people exposed to family violence. However, we recognise that in the context of family violence this should not be an exclusive focus and needs to sit within a broader conceptual framework to address family violence. Such an approach is similar to the broad public health approach that underpins the Coalition of Australian Governments endorsed *National Framework for Protecting Australia's Children*.[10]

To assist our understanding, the Centre has started work on a conceptual framework which we refer to as *Family Violence: The Seven Cs.* The framework contains seven domains or components which are depicted in the chart below:

CHART ONE

Each domain is described in more detail in Table 3 below:

[10] National Framework for Protecting Australia's Children 2009-2020, *An Initiative of the Council of Australian Government,* April 2009

TABLE 3: FAMILY VIOLENCE: THE SEVEN Cs

Domain	Description
CULTURE	Refers to how family violence is defined and understood in the community and community sector
COMMUNITY	Refers to the role of the broader community and service infrastructure in preventing and supporting victims of family violence
CONTROLS	Refers to the range of legal controls and interventions that respond to family violence, protect victims and hold perpetrators to account
CAPACITY	Refers to how the available service responses support victims
CAPABILITY	Refers to the skills and competencies required of practitioners to respond effectively to family violence
CO-ORDINATION	Refers to how services are co-ordinated and integrated
COMMUNICATION	Refers to how services communicate and share information about victims and perpetrators of family violence

The Centre contends that comprehensive, effective responses to family violence in the Victorian community will need to address key issues and questions in each of these seven domains. Our assessment is that on current policy settings, considerable attention is required to attend to and improve the operation and effectiveness of each of these domains:

- Culture: there remain unacceptably high levels of family violence in the community suggesting significant attitudinal shifts are required including to women and their children. Within the service sector there are different paradigms about the nature of family violence and appropriate responses.
- Controls: legal controls and interventions have improved over the last decade but more needs to be done to integrate and sharpen these controls and interventions.
- Capacity: demand for services far outstrips available capacity resulting in many families not getting the help they need, early enough.
- Capability: there are many skilled and competent practitioners but many professionals and services fail to see the signs of family violence and case practice is not well-integrated. The impact of cumulative harm upon children is not widely recognised.
- Co-ordination: is patchy and inconsistent resulting in double handling and inefficiencies. Multi-disciplinary approaches however are showing promise.
- Community: there is clearly growing awareness within the community about the harmful effects of family violence. Translating this awareness into positive action and responses across the community is a work in progress that has just begun.
- Communication: there are limited legal protections to share information and outdated IT systems resulting often in in poor, untimely communication between services and lost opportunities to better support victims and families.

Measuring progress against each of these domains will provide good evidence of how well we are doing as a community to address the impacts of family violence and where we need to do better. The Andrews Labor Government has recently announced funds to develop a *Family Violence Index*. This is a positive initiative that will greatly assist in gauging progress.

KEY RESPONSES TO QUESTIONS

QUESTION ONE

Which of the reforms to the family violence system introduced in the last ten years do you consider most effective? Why? How could they be improved?

FAMILY VIOLENCE REFORMS

The establishment of the *Statewide Steering Committee to Reduce Family Violence*, in 2002 was an important initiative, signifying serious intent by the Victorian State Government to address family violence. Steering Committee members included representatives from police, government departments, family violence services, the courts, peak bodies for family violence, support organisations for sexual assault victims, the *No to Violence Male Family Violence Prevention Association*, legal services and the *Victorian Health Promotion Foundation*. This Committee advised on the need for, and developed a model for, an integrated response in Victoria. The Government also established an *Indigenous Family Violence Task Force* in 2002.

The Committee was instrumental in a number of initiatives including:

- reforms to family violence and sexual offences legislation, based on the recommendations from the Victorian Law Reform Commission
- a new Code of Practice and five-year strategy plan for the Victorian police in respect of family violence
- the establishment of specialist family violence courts, as well as sexual assault lists and prosecution teams and multi-disciplinary sexual assault centres
- the provision of counselling and offender treatment programs in the context of family violence and sexual assault
- the establishment and funding of a child witness service
- funding for the Department of Human Services to develop partnerships with community and local organisations to provide integrated services such as housing, counselling and treatment programs (known as the Integrated Family Violence Service program)
- the development of a comprehensive risk assessment framework and tools
- a ten-year plans to address Indigenous family violence and prevent violence against women[11]

The *Family Violence Protection Act* 2008 introduced greater legal protections for women affected by family violence. Accompanying major cultural changes within Victoria Police produced improvements in the *'first response'* to reports about family violence. As a result public recognition and awareness of family violence has improved in Victoria in the last decade. However, the Centre considers that this has not been matched by sufficient investment in services working with victims of family violence.

The last decade has also provided a number of examples of services co-locating to provide a more coordinated, multi-disciplinary response to vulnerable families, including families affected by family violence.

CHILD FIRST AND INTEGRATED FAMILY SERVICES

Commencing in 2002 in a series of pilots, the co-location of community based child protection practitioners in family services settings has been positively received and evaluated. Recognising that family services were often working with highly vulnerable children the co-location of community based child protection practitioners (out posted from the statutory child protection program) allowed family services practitioners to have access to the specialist knowledge of child protection practitioners. The evaluation of the reforms[12] observed that:

[11] See the Australian Law Reform Commission Final Report *Family Violence—A National Legal Response*, 2010

[12] KPMG, Department of Human Services*, Evaluation of the Child and Family Service Reforms,* Stage 1A Final report, 2011. Accessed at:
http://www.dhs.vic.gov.au/__data/assets/pdf_file/0008/646820/childFIRSTandintfamservicesfullreport_09082011.pdf

> *Community Based Child Protection (CBCP) is adding to the capacity for collaboration between Child FIRST and Integrated Family Services and Child Protection. This role adds value in terms of referral between Child FIRST and Child Protection, offers secondary consultation and advice, undertakes joint visits and joint case management, participates in allocations meetings and educates Child Protection and Integrated Family Services staff about the relative roles and responsibilities of each sector.*[13]

This approach was incorporated in the mainstreaming of Child FIRST/Integrated Family services and community based child protection practitioners are now collocated with Child FIRST in all catchments across the State. Total funding for Child FIRST and Integrated Family Services is significant at over $90 million per annum in 2015-16.

The evaluation of the child and family services reforms[14] observed that:

> *Since the introduction of Child FIRST and Integrated Family Services more families have been able to access community based earlier intervention services. Family Services are now targeting more vulnerable families, who without support may be at-risk of entry to the statutory Child Protection system. In general, families are now receiving more intensive support (of over 40 hours) to build parenting capacity, resilience and address their complex needs.*[15]

Significantly, the evaluation also observed that many more families were now accessing more intensive support:

- *Over twice as many service hours were provided to families in 2010-11 compared to 2005-06.*
- *Families are demonstrating on average twice as many complex risk characteristics as before the reforms.*
- *Of the families involved with Child in the 12 months to March 2011:*
  - *25 percent had Child Protection involvement, compared to 13 percent in 2005 – 06*
  - *32 percent involved family violence, compared to 23 percent in 2005-06*
  - *16 percent involved substance abuse, compared to 9 percent in 2005 – 06.*
- *More families received intensive intervention: over 41 per cent of cases now receive 40+ hours, compared to 25 per cent of cases in 2005-06.*[16]

Some two years after the KPMG evaluation, the *Protecting Victoria's Vulnerable Children Inquiry* (PVVCI) report[17] made some cautionary observations about the operation of Child FIRST/Integrated Family Services*:*

> *The combined effect of increased demand for family services, increased complexity of client needs, and the priority given to high-needs clients is that there appears to be a lack of capacity among family services agencies to work with a broader range of children and families.*[18]

The Inquiry also recommended further integration of intake arrangements involving services working with vulnerable children:

> *The Inquiry considers that co-locating intake processes so that statutory child protection practitioners sit physically alongside their community service organisation Child FIRST intake counterparts would drive greater collaboration and knowledge-sharing about protective risk assessment. Such a change would, over time, evolve the current community based child protection practitioner function to area-based, co-located intake teams. The Inquiry recommends that a pilot approach be adopted for co-locating intake as a foundation reform.*[19]

[13] ibid.
[14] Ibid. p.2
[15] ibid. p. 4
[16] ibid. p.10
[17] Protecting Victoria's Vulnerable Children Inquiry Report, 2012
[18] Ibid. p. 174
[19] Ibid, p.xliii

To date this latter PVVCI recommendation has not been acted upon. The Centre considers that the recommendation should now be revisited. The existence of multiple entry and intake points, in family violence, in child protection and in family services is clearly not efficient and inevitably results in double-handling of clients and missed opportunities.

The recent restructure of the Department of Health and Human Services into 17 areas closely aligns with the 24 Child FIRST/Integrated Family Services catchments. There could be merit in a trial of the consolidated intake and referral service as recommended in the PVVC.

MULTI-DISCIPLINARY CENTRES

A notable innovation in the last decade was the introduction of multi-disciplinary centres for victims of sexual assault, many of which occur in a family violence context. Child victims of sexual assault involving family members or victims subject to sexual assault in an out of home care setting typically encounter three separate service systems in the immediate aftermath of the assault – Victoria Police, Sexual Assault Services and Child Protection. At the instigation of local practitioners, a pilot multi-disciplinary centre involving these three services was piloted in the Frankston area in 2007. The pilot aimed to provide a collaborative, co-located investigative and support response to victims of sexual assault. A positive evaluation of the pilot by Deakin University[20] led to the provision of funding to establish multi-disciplinary centres in six locations. Currently three are operational (Frankston, Mildura and Geelong) with planning for the remaining three centres (Dandenong, Bendigo and La Trobe Valley) underway.

TASKFORCE ALEXIS

Taskforce Alexis is a multidisciplinary project operating since late 2014 in the Melbourne suburbs of Bayside, Kingston and Glen Eira. The model includes involvement from Victoria Police, Child First, Integrated Family Services, family violence services, mental health practitioners and other agencies partnering to provide support to recidivist family violence cases. Two Integrated Family Services workers are made available to the Police to provide "pre Child First" support. This model is in its early days but the Centre understands is showing very positive results around increased engagement with Child FIRST and increased referrals to Integrated Family Services.

L17 FAMILY VIOLENCE PROJECTS

Two pilots were established in North East Melbourne and Hume Moreland Child FIRST catchments to trial a new approach to responding to family violence referrals, commonly referred to as L17 referrals, from Victoria Police. When police attend a family violence incident they are required to conduct a risk assessment and refer (an L17 referral) all parties involved to appropriate services.

In each site, the Child FIRST provider (the Children's Protection Society and Kildonan, respectively) partnered with the Department of Human Services Child Protection, Victoria Police, the Victorian Aboriginal Child Care Agency and Berry Street. The project partners meet twice-weekly with responsibility for assessing all L17 referrals to determine the best response.

The aim of the Family Violence L17 Project was to provide a more effective response to family violence incidents. By providing a collaborative and streamlined approach, information is shared amongst all parties and appropriate interventions are identified to support the children and families that have been impacted by family violence.

The L17 Project is currently subject to an evaluation by the University of Melbourne.

SERVICES CONNECT TRIALS

A series of *Services Connect* trials, most involving a Child FIRST community services organisations as the lead, commenced in a number of Department of Health and Human Services catchments in early 2015. Partners involved in the trials vary from site to site but generally includes Integrated Family Services, Homeless services,

[20] Powell, M and Hughes-Scholes, C. Evaluation of the Sexual Offence and Child Abuse Investigation Team (SOCIT) and Multidisciplinary Centre Pilot Program, Deakin University, 2012

drug and alcohol services and community mental health services. Funding for each trial site amounted to approximately $500K and included an expectation that providers in each consortium would contribute 'in kind' to the *Services Connect* approach, usually in the form of one or more full time equivalent (FTE) staff members.

There is a range of views across the community sector about the distinctive *Services Connect* approach and also emerging evidence of a number of challenges as the trial sites establish and consolidate their operations. While there are some issues in the design, role and focus of these trials, the co-location of services is showing early promise. There could be potential to refresh and re-align the *Services Connect* approach, possibly operating as a specialist, multidisciplinary team within Integrated Family Services. It would have a strong focus on early intervention and prevention responses with a particular focus on family violence. If this were to occur, engagement with the specialist family violence services on service design would be critical. The approach would utilise the key worker approach to provide counselling and support to families and children and target families that may not be eligible for services elsewhere in the service system.

Multi Agency Safeguarding Hubs

A common theme underpinning recent Victorian reform efforts has been the co-location of professionals in multi-disciplinary settings. Similar results and findings were evident in the UK Multi Agency Safeguarding Hubs (MASH)[21]. Key early findings from a UK study include:

Whatever the precise set-up of local multi-agency information sharing models, all areas reported that they felt these new approaches had positive outcomes for their service and service users. These included:

- *More robust decision making among professionals because decisions are made based on sufficient, accurate and timely intelligence. Professionals have said they are better able to step up and step down risk assessments allowing for better allocation of resources and more appropriate services for users.*
- *Working together avoids duplication of process across agencies. Greater efficiencies in process can mean re-allocation of resources to other areas i.e. Child Sexual Exploitation/Prevent.*
- *An increase in the uptake of the use of early help assessments, such as the use of the Common Assessment Framework (CAF).*
- *A reduction in repeat referrals and cases ending in 'no further action' through earlier sharing of information leading to earlier intervention in cases.*[22]
- *Better Information sharing across partners – enables better safeguarding of the children and young people involved as concerns which initially appear to be of a low level when seen in isolation, are sometimes recognised as part of a long standing pattern of abuse and neglect which needs a response when information is pooled together.*
- *Improved engagement of health partners – where involved – engagement of health partners had proved particularly valuable and beneficial across agencies, in helping to identify risks and intervene early.*
- *Improved knowledge management – partner organisations (and the staff within them) develop a better understanding of the work undertaken by each organisation.*
- *Reduces the risk of 'borderline cases' slipping through the net without any action being taken.*

[21] UK Home Office, Multi-Agency Working and Information Sharing Project, Early Findings, July 2013. Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/225012/MASH_Product.pdf
[22] Ibid. p.4-5

Question Two

The Royal Commission wants to hear about the extent to which recent reforms and developments have improved responses to family violence, and where they need to be expanded or altered.

Responses based on multi-disciplinary approaches described in the responses to Question One have clearly improved responses to family violence.

The Centre notes however that not all these initiatives and reforms are aligned or form part of a coherent, overarching strategy. Most of the key reforms that focussed on bringing practitioners together in multi-disciplinary teams began as pilots or trials – including Child FIRST, Multi-Disciplinary Centres, the L17 Family Violence Project and the *Services Connect* trials. Child FIRST is the only reform to date that has been fully mainstreamed across the State.

The Centre observes a frequent tendency of governments to respond to the identification of new social problems with new programs. Although well-intentioned, such policy responses often lead to greater complexity and siloed service delivery, as each new program carves out a new operating space and claims privileged expertise within that space. The unintended consequences of such policy reform are often insufficiently thought through and in some circumstances can lead to serious policy failure.[23]

The Centre considers a key focus for Government should be on investing energy and resources in bringing services together in existing multi-disciplinary settings rather than setting up new, stand-alone multidisciplinary arrangements. Child FIRST and Integrated Family Services are now well-established and operate on a statewide basis. Future reforms, particularly those affecting children affected by family violence should build on and expand the capacity of this existing platform. One practical measure that could be implemented quickly would involve funding co-located family violence practitioners from Family Violence services in Child FIRST and Integrated Family Services. This builds on the positive evaluation of the co-located community based child protection practitioner in Child FIRST and would enhance the capacity and quality of service responses to families affected by family violence.

In Victoria, serious sexual or physical abuse allegations involving children result in a joint investigation by Victoria Police accompanying child protection practitioners from the Department of Health and Human Services on the first visit to the family. Victoria Police focus on their law enforcement and evidence-gathering responsibilities and the child protection practitioner can focus on assessing the safety of the child or children. This approach is taken a step further in the *Multi-Disciplinary Centres* with the involvement of sexual assault services also assisting in the initial planning and service response.

The Centre considers that a similar approach could also work well in the most serious, high risk family violence matters, with social welfare practitioners involved in the planning of the initial response and accompanying Victoria Police on the initial call out response. The Centre considers this would enhance the prospects of subsequent effective engagement with the necessary crisis and support services.

The *Children, Youth and Families Act* 2005, operational from 2007, included new provisions that enabled Child FIRST and Integrated Family Services to receive referrals relating to concerns about a child's wellbeing. The Act also authorised certain professionals to share information with child protection and Integrated Family Services (including Child FIRST) about vulnerable children and families.

Effective service provision is heavily dependent upon relevant information being accessible, available and shared by services. Families often receive services from more than one agency and sharing information between these agencies invariably results in more informed interventions.

[23] See King, A. and Crewe, I.,*The Blunders of Government*, 2013

The information sharing provisions in the 2005 Act have operated well. **The Centre considers similar provisions could be introduced in the *Family Violence Act* 2008 or the *Children, Youth and Families Act,* 2005 to enable services working with victims and perpetrators of family violence to more effectively seek and share information.**

Information sharing with the Federal jurisdiction is also important to the safety of women and their children. Current restrictions apply to family counselling providers in transmitting information about adult victims and perpetrators unless the safety of a child is a concern. Further review of this aspect of information sharing is required but will require State and Australian government cooperation.

Over the last decade family violence reform has primarily focussed on strengthening crisis and statutory responses. Less attention has focussed on prevention and early intervention. **The Centre considers this should be a high priority for future reform.**

QUESTIONS EIGHT TO ELEVEN

Tell us about any gaps or deficiencies in current responses to family violence, including legal responses. Tell us about what improvements you would make to overcome these gaps and deficiencies, or otherwise improve current responses.

Respondents to the Centre's survey highlighted two particular gaps and deficiencies in current service arrangements:

1. Access to Men's Behaviour Change programs was described as often difficult or problematic. An absence of men's treatment services was associated with relapse and repeated family violence incidents.
2. Asked to identify any emerging new trends, survey respondents frequently identified growing number of referrals to Child FIRST involving child, (usually an adolescent child) to adult violence occurring in the family home[24].

Investment in Men's Behaviour Change Programs has clearly not kept pace with growing demand. Additional investment is required to meet this demand

Child to adult violence is also presenting significant challenges for families, compounded by the lack of services with the necessary skills to address this type of violence.

Investment in additional capacity in evidence-based Men's Behaviour Change programs and services providing support for families affected by child – parent violence is urgently required.

Does insufficient integration and co-ordination between the various bodies who come into contact with people affected by family violence hinder the assessment of risk, or the effectiveness of (early intervention, crisis and ongoing) support provided, to people affected by family violence? If so, please provide examples.

What practical changes might improve integration and co-ordination? What barriers to integration and co-ordination exist?

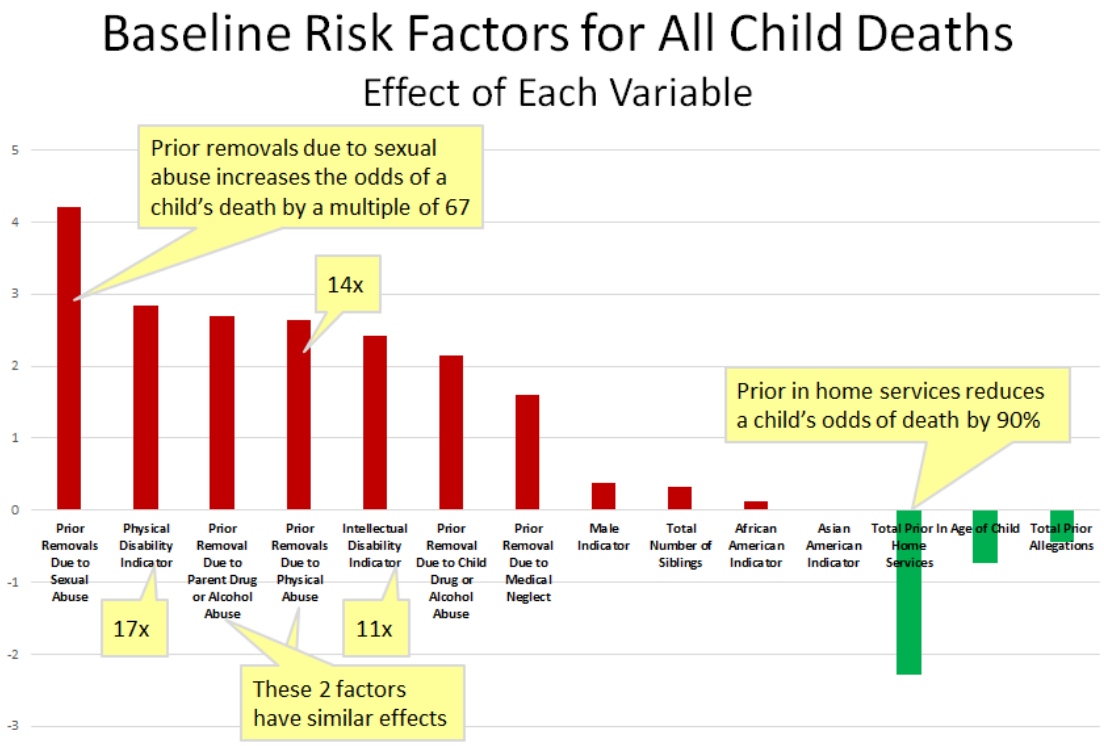
What are some of the most promising and successful ways of supporting the ongoing safety and wellbeing of people affected by violence? Are there gaps or deficiencies in our approach to supporting ongoing safety and wellbeing? How could measures to reduce the impact of family violence be improved?

Recent American research has highlighted the critical role that in-home services to vulnerable families can play in preventing child fatalities. A meta-analysis[25] of all child deaths known to child protection in the State of Florida between 2009 and 2013 examined key risk and protective factors. This data was then compared with outcomes for all other children known to Florida child protection in the same period. The analysis identified the expected high risk factors often associated with non-accidental child fatalities in the home – prior physical or sexual abuse, drug and alcohol misuse and so on. Significantly, the key protective factor found to have most impact on preventing child deaths was what is described as *'prior in-home service'*. Key findings from the research are shown below:

> *"When reading the following chart, factors in red above the 0-axis line are negative risk factors that increase the odds of death while those below (in green) are positive risk factors that reduce the odds of death.*

[24] Recent media reports indicate that Victoria Police were called to more than 4,000 incidents in 2014 where children were the perpetrators. Source: http://www.abc.net.au/news/2015-05-19/parents-seek-police-help-over-domestic-abuse-violent-children/6481442

[25] Florida Department of Children and Families Executive Digest, *Child Fatality Trend Analysis January 1, 2007 through June 30, 2013.* Accessed at: https://s3.amazonaws.com/s3.documentcloud.org/documents/1390965/child-fatality-trend-analysis-florida-department.pdf



The research observed that:

- *Prior in-home services reduce the odds of death by 90%*

> *This would indicate that visits to the home have a positive impact on keeping children safe. To lower a child's risk of death, more in-home services would be recommended. This effect was observed in the Abuse and Drowning categories. It was not statistically significant in the Asphyxiation category.*[26]

The Florida research does not discuss how or why prior in-home services operate as such a powerful protective factor in preventing child fatalities. However, discussions with Centre members have identified the following factors that may account for the positive impact of in-home services in preventing child fatalities:

- In-home support may lead to earlier detection of stress factors within the home that can then be addressed through referral to relevant specialist services or supporting the victim to separate from the perpetrator.
- In-home support may play a role in modelling good parenting and acceptable male behaviour within relationships and assisting family members to address particular 'triggers' that may lead to poor parenting or violence escalating in the home.
- In-home support may act as a deterrent to perpetrators of violence by challenging and exposing the 'veil of secrecy' that is often associated with violence in the home.
- In-home support may empower actual or potential victims to speak out about violence in the home. This in turn may trigger the involvement of relevant law enforcement and victim support agencies to protect victims within the home.

The Centre recommends the expansion of in-home support services in future investment strategies designed to reduce the incidence and harmful effects of family violence.

Responses to questions about the L17 Family Violence referrals in the Centre's survey of Child and Family Alliances revealed significant variation in the volume and quality of referrals across the 24 catchments. Some

[26] ibid. p.5

Child FIRST catchments reported exceptionally high volumes of L17 referrals. In these catchments only a very small proportion of the L17 referrals were triaged through to a service intervention, largely due to capacity limitations within Integrated Family Services and/or the broader service system. Concerns were also raised about the quality of L17 referrals and the capacity to seek further information.

Other jurisdictions have adopted different approaches to managing the referral process from Police to support services. For example, New South Wales[27] has established Child Wellbeing Units in lead agencies that provide a preliminary triage of new Family Violence referrals. This approach may result in more effective triage arrangements and better quality referrals. The approach also has the virtue of sharing risk and responsibility across all key government agencies responsible for family violence – police, education, health and human services.

The Centre recommends the Commission examines the operation of the L17 referral process and approaches in other jurisdictions.

Under s.61 (b) of the *Children, Youth and Families Act 2005* Child FIRST and Integrated Family Services are required to prioritise services based on need.

Responses to the Centre's survey indicated that the majority of families referred through the L17 referral process did not receive a service intervention. While there are a broad range of reasons for low levels of service intervention, including some limitations in the L17 referral process, survey feedback indicated that lack of capacity within Integrated Family Services was an important factor. This reflects the limited capacity within Integrated Family Services to accept referrals – even where there may be clear evidence of need.

Since Integrated Family Services commenced in 2007, there has been limited additional new funding to reflect growing population and growing demand. This translates into a requirement for Child FIRST to manage incoming demand carefully and limit onward referrals to Integrated Family Services. As observed by the PVVCI this means that many families, including families experiencing family violence that could benefit from a family service intervention are unable to receive the services and supports they need.

The Andrews Government 2015 State Budget included a $48 million boost over four years to funding for Child FIRST and Integrated Family Services. This new investment will increase available service capacity by approximately ten per cent within Child FIRST and Integrated Family Services, with improved capacity to work with victims of family violence.

The Centre recommends that given population growth, particularly in the growth corridors and the current rising trajectory in reports of family violence there will be an ongoing need to regularly review funding for support services to reflect need in the community. Crisis services, including Family Violence services and Homelessness services, also face similar demand pressures and capacity constraints and any new investment by Government should respond to these demand pressures.

One of the most striking features of current service responses to family violence in Victoria is the absence of a common, consistent and shared understanding of family violence across services working with victims - its causes, consequences and the most appropriate responses. This largely reflects the more recent emerging understanding of family violence and the challenges involved in integrating that understanding into mainstream service provision provided in other service sectors.

Child and family services, including child protection are guided in their practice by the *Children, Youth and Families Act, 2005* which places the best interests of the child as the paramount consideration. In contrast the family violence sector, with its origins in the women's movement has traditionally viewed the needs and safety of the adult female victim of family violence as the key consideration. These different perspectives can lead to tensions between the respective services. There are however encouraging signs that these differences in focus and understanding are being addressed and worked through. Co-location of staff in multi-disciplinary settings has brought new shared insights and understanding.

[27] For further information on the establishment of Child Wellbeing Units see the NSW Inter-Agency Guidelines. Available at: http://www.community.nsw.gov.au/kts/guidelines/roles/cwu.htm

The *Child Wellbeing and Safety Act* 2005 included principles for children that were intended to be used for guidance in the development and provision of Government, Government-funded and community services for children and their families. The principles are set out in s.5 of the *Child Wellbeing and Safety Act* 2005.

The Centre considers there could be merit in amending these principles, or introducing new principles in the *Family Violence Act, 2008* to create a set of explicit legislative principles that would apply to all services working with the victims of family violence, both children and adults.

The Victorian Auditor-General's Report on ***Early Intervention Services for Vulnerable Children and Families*** was released on Wednesday 27th May 2015

The objective of this audit was to determine the effectiveness of community-based child and family services for vulnerable children and families. Specifically the audit examined whether:

- community-based child and family services are improving outcomes for vulnerable children and families
- vulnerable children and families are able to access community-based child and family services as needed.

The audit found that growing demand and complexity of referrals resulted in Child FIRST and IFS prioritising intervention to high needs families, resulting in low-medium risk families, who would benefit most from the intervention to prevent escalation of their vulnerabilities, missing out on receiving a service. The audit states that data limitations and lack of outcomes monitoring at the system level make it unclear whether these services are effectively meeting the needs of vulnerable families.

The audit states there is a need to improve strategic planning, strengthen partnerships and governance arrangements, and improve communication across local, divisional and central levels of the department and with alliances by DHHS. It also needs to improve the quality of engagement with service providers, better monitor program risks through routine and systematic data analysis, identify and address key performance issues and measure outcomes.

The audit's overarching recommendation is for a comprehensive and urgent whole-of-system review of early intervention, including funding, supported by nine specific recommendations that DHHS:

1. improves planning by better demand forecasting and more systematic analysis of existing program performance data—including analysis of the level and nature of non-substantive referrals—to understand gaps in service response
2. develops a regular statewide engagement mechanism to identify issues and risks in a timely manner and to design solutions with the input of the service sector
3. provides targeted training to service providers in catchment planning and data analysis
4. reviews its whole-of-system funding for early intervention to better reflect the impact of demand drivers on Child and Family Information, Referral and Support Teams and Integrated Family Services
5. provides targeted support to those Child and Family Services Alliance members whose partnerships are still underdeveloped, and supports them to become more collaborative in their interactions
6. investigates and implements ways of improving the effectiveness of its communications about operational and strategic issues between and across the department centrally, regionally and locally, and with community service organisations
7. provides explicit requirements for its local and divisional staff regarding the monitoring of operational risks, emerging issues, and the capacity and capability of the partnerships involved in the local Child and Family Services Alliances
8. develops a set of standard analytical data sets for the Child and Family Services Alliances to use to monitor and report on the timeliness and effectiveness of their engagement with clients at the program level, including rates of failure to engage, referral outcomes re-referrals and re-reports
9. undertakes statewide performance analysis using catchment data to facilitate sharing of practices among Child and Family Services Alliance members.

The Centre supports the recommendations from the VAGO report, and believes that the Royal Commission should actively work with the Department of Health and Human Services to ensure that the whole-of-system review addresses the integration of a range of responses to the needs of families, including early intervention.

QUESTIONS SEVENTEEN TO NINETEEN

Are there specific cultural, social, economic, geographical or other factors in particular groups and communities in Victoria which tend to make family violence more likely to occur, or to exacerbate its effects? If so, what are they?

What barriers prevent people in particular groups and communities in Victoria from engaging with or benefiting from family violence services? How can the family violence system be improved to reflect the diversity of people's experiences?

How can responses to family violence in these groups and communities be improved? What approaches have been shown to be most effective?

Responses to the Centre's survey indicated that Aboriginal and Torres Straits Islander families accounted for up to 18 per cent of referrals to Child FIRST in 2013-14. Recent emerging findings from the ongoing investigation of Aboriginal children in out of home care (*Taskforce 1000*) by the Victorian Aboriginal Commissioner for Children and Young People indicate that a very high proportion (+95 per cent) of Aboriginal children in out of home care have family violence present in their family background. Aboriginal children are also significantly over-represented in Victoria's child protection system and family violence is also a key characteristic in many of the children's family background. Survey respondents also commented on high levels of intergenerational trauma within Aboriginal families. The *Strong Culture, Strong Peoples, Strong Families 10 year plan*[28] sets out a detailed plan to address the particular needs of Aboriginal families experiencing family violence. The plan was developed in conjunction with community representatives.

While most survey respondents reported it was difficult to access data on families from Cultural and Linguistically Diverse (CALD) communities, including asylum seekers, involved with Child FIRST/Integrated Family Services, it was clear that CALD families are significantly over-represented in parts of the State.

Many respondents commented on the need to work closely with Aboriginal Community Controlled Agencies (ACCOs) and specialist services working with CALD families. The Centre considers that Aboriginal and CALD families experiencing family violence have particular needs that often cannot be met through mainstream service provision.

New investment in support services should include detailed consideration of the needs of Aboriginal and CALD families and include a focus on increasing the service capacity of ACCOs and specialist services for CALD families working with families experiencing family violence.

The role of family violence in substantiated child protection cases has been identified. Many children and young people in out of home care who have experienced family violence require reparative and therapeutic care. Investment for this group should provide access to specialist therapeutic intervention to break the cycle of violence.

[28] Department of Planning and Community Development, *Strong Culture, Strong Peoples, Strong Families* Towards a safer future for Indigenous families and communities 10 year plan, 2008

QUESTION TWENTY-ONE

The Royal Commission will be considering both short term and longer term responses to family violence. Tell us about the changes which you think could produce the greatest impact in the short and longer term.

Noting the Centre's focus in this submission on the needs of children exposed to family violence, the Centre has identified the following priority actions for consideration by the Commission:

1. Invest in strengthening service capacity to intervene earlier with families experiencing family violence. This should be a high priority for both short and long term future reform. Short term priorities include:

    - Expand in-home support services in future investment strategies designed to reduce the incidence and harmful effects of family violence.
    - Invest in additional capacity in Men's Behaviour Change programs and services providing support for families affected by child – parent violence
    - New investment in support services should include detailed consideration of the needs of Aboriginal and CALD families and include a focus on increasing the service capacity of the ACCOs and specialist services.

2. Given significant population growth, particularly in the growth corridors and the current rising trajectory in reports of family violence, there will be an ongoing need to regularly review funding for services working with family violence victims and perpetrators to reflect need in the community. Crisis services, including Family Violence services and Homelessness services, also face similar demand pressures and capacity constraints and new investment by Government should respond to these demand pressures.

3. Effort and resources should be directed to bring services together in existing multi-disciplinary settings rather than setting up new, stand-alone arrangements. Child FIRST and Integrated Family Services are now well-established and operate on a statewide basis. Future reforms, particularly those affecting children affected by family violence should build on and expand the capacity of this existing platform. One practical measure that could be implemented quickly would involve funding co-located family violence practitioners from Family Violence services in Child FIRST and Integrated Family Services to ensure a range of responses to meet the needs of families, including early intervention.

4. Consider expanding the role of Multi-Disciplinary Centres to include joint initial responses to the most serious, high risk family violence matters, with social welfare practitioners involved in the planning of the initial response and accompanying Victoria Police on the initial call out response.

5. The existence of multiple entry and intake points, in family violence, in child protection and in family services is clearly not efficient and inevitably can result in double-handling of clients and missed opportunities. The recent restructure of the Department of Health and Human Services into 17 areas closely aligns with the 24 Child FIRST/Integrated Family Services catchments. There could be merit in a trial of the consolidated intake and referral service as recommended in the Protecting Victoria's Vulnerable Children Inquiry.

6. Review the operation of the L17 referral process and potential applicability in Victoria of approaches used in other jurisdictions.

7. Introduce new, or amend existing legislation, to improve information sharing between services and professionals working with family violence victims and perpetrators.

8. Consider legislative amendments to create a set of explicit legislative principles that would apply to all services working with the victims of family violence, both children and adults.