Service system responses to children and young people in the statutory child protection system who have experienced or witnessed family violence

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Acknowledgements

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Glossary

The following glossary relates directly to the quantitative data supplied in 2018 by the Queensland Department of Child Safety, Youth and Women (Tables 1 through to 6).

Abused as a child (Intergenerational experience of abuse or neglect)
The primary parent has a history of being abused or neglected as a child. Evidence of abuse includes credible statements by the primary parent or others. Information relating to the primary parent may also be obtained from departmental records, or from interstate or overseas child protection systems.

Criminal history
The primary parent has been charged or convicted of offences as either an adult or a juvenile.

Domestic and family violence
The household experienced two or more instances of domestic and family violence during the last 12 months. This includes all physical assaults and periods of intimidation, threats or harassment between parents or between one parent and another adult in the home.

Drug or alcohol problem
A parent had a drug and/or alcohol problem during the last 12 months, or at any other time prior. This includes instances where drug or alcohol abuse interfered with parent or family functioning, such as where family or marital relationship was disrupted, employment was affected, or the parent engaged in criminal activity in the

High or Complex Needs Children
A child in the household has significant physical or developmental disability, including a formal diagnosis of an intellectual disability, a learning disability indicated in school records or another developmental problem; is medically fragile, such as diagnosed as failure to thrive; or had a positive toxicology report for alcohol or drugs at birth.

Households
One or more persons who have primary responsibility for the care of the child.

Housing/Homelessness
The family is homeless or about to be evicted. This includes people who are living in a shelter and those living on a short-term basis with relatives or friends.

Inappropriate Parental Attitudes and Behaviours
The primary parent deprives the child of affection or emotional support; is emotionally abusive towards the child; their disciplinary practices have caused, or are likely to cause, harm to the child because they were excessively harsh or inappropriate to the child's age or development; or is domineering, indicated by controlling, abusive, overly-restrictive or unfair behaviour, or over reactive rules.

Mental illness
The primary parent had a mental health problem during the last 12 months, or at any other time prior. This includes diagnosed mental health disorders (as per the Diagnostic and Statistical Manual), or instances where the parent was repeatedly referred for psychological/mental health assessments or recommended for treatment or hospitalisation by a psychiatrist or mental health authority.

Physical Care Inconsistent with Child Needs

The physical care (e.g., age-appropriate feeding, clothing, shelter, hygiene and medical care) provided to the child by the primary parent threatens the child's wellbeing or results in harm to the child; or the current housing situation is physically unsafe and does not meet the health or safety needs of the child (e.g. exposed wiring, inoperable plumbing, cockroach/rat infestations, human/animal faeces on floors, rotting food).

Prior Notifications

Prior Child Safety notifications for abuse or neglect, including all prior notifications in which any adult member of the current household has been alleged responsible for abuse or neglect of a child, regardless of whether the subject child in these notifications are subject children in the current history are. Where applicable, child protection history from other state jurisdictions and New Zealand is checked, and any relevant notifications alleging abuse or neglect counted.

Prior Ongoing Intervention

The department has provided ongoing intervention to the household prior to the current investigation and assessment, including ongoing intervention that was open when the current notification was received. Where applicable, child protection history from other state jurisdictions and New Zealand is checked and included.

Prior Out of Home Care

The department has previously placed any child from the household in out-of-home care prior to the current investigation and assessment. Includes any previous investigations and assessments during which a child from the household was removed from and placed outside the family home.

Young parent

A household where at least one parent is 21 years or younger.

Source: Queensland Department of Child Safety, Youth and Women - Family and Household Characteristics: Glossary, 2019.

1. Executive Summary

In recent years, children and young people's exposure to family violence has become a prominent policy issue within Australia. There has been a growing need to understand in more detail the service system responses to these children and young people, specifically the response they receive within the statutory child protection system.

To understand these service system responses in more detail, the Australian Government Department of Social Services (DSS) commissioned the ACU Institute of Child Protection Studies (ICPS) to undertake a project to develop and pilot a methodology to investigate service system responses for families where child protection concerns exist within the context of family violence. The aim was to understand the nature of services (and particularly whether they were child-centred), and the case-management approach and service system pathways for children and young people exposed to family violence and who have had substantiated child protection concerns.

The Queensland statutory child protection service (Department of Child Safety, Youth and Women) agreed to participate and provide data for the pilot.

The project comprised four stages: a literature review, quantitative data analysis, semi-structured qualitative interviews and data synthesis.

The focused literature review assessed the intersection between child protection and family violence systems.

The quantitative data analysis examined data tables provided by the Queensland Department of Child Safety, Youth and Women (see section 4). The analysis highlighted key characteristics of children and families reported to the Queensland child protection service with issues of domestic and family violence in the period between 1 July 2015 – 31 December 2016. Most of these cases were from non-Indigenous households. Alcohol and drug use represented one of the highest family risk factors in all households involved with the Department. Young parents (aged 14-19 years) were more likely to have domestic and family violence identified as a risk factor than older parents (aged 20 plus).

The semi-structured qualitative interviews were conducted with the Department's Child Safety Officers (CSOs) and practitioners from non-government agencies (or external service providers) in the South West child protection region of Queensland. The interviews were conducted with CSOs on cases which they had been previously been involved with during the period from 1 July 2015 – 31 December 2016. Twenty-eight CSOs and seven practitioners from non-government agencies participated. In these 35 interviews, we explored the referral pathways, and the nature of interventions for children and families with issues of domestic and family violence.

The synthesis of available data served two purposes. It enabled reflections on the effectiveness of services responses. Additionally, it provided insights into efficacy of the approach (or methodology) adopted to learn more about what happens to the children and families reported to child protection with issues of domestic and family violence for the specific time period between 2015–2016.

The most effective service responses were reported to us as ones that were child-centred. They involved working with children and young people to identify and meet their needs. We identified some key principles of child-centred practice, namely: open, regular communications with children and young people to build rapport, co-identification of needs and wishes with children and young people themselves, and consistent involvement (or provision of opportunities for involvement) for children and young people in the case-management process.

Several enablers and barriers to child-centred practice at that time were identified. Enablers included information sharing and collaborative practice amongst all service providers. Barriers to child-centred

practice were identified as poor communication (lack of information sharing), lack of specialist services, and a lack of experts for children and young people to work with in the statutory child protection system.

The pilot study demonstrated the value in asking about and looking for evidence of child-centred service responses for children affected by domestic and family violence who come to the attention of statutory child protection authorities. However, it was not without its challenges. The initial identification of child protection cases involving domestic and family violence from across the whole of Queensland was difficult. The Integrated Client Management System (ICMS) used by the Queensland Department of Child Safety, Youth and Women ("the Department") does not include domestic and family violence as an individual indicator of concern in child protection cases as it is not a separate harm type under the legislation in Queensland (or in fact any other jurisdiction) to which statutory authorities have legislative authority to intervene (CFCA, 2019).

Resource-intensive processes were therefore required to identify domestic and family violence in child protection cases for the period between 2015–2016. Further intensive resources were required to contact statutory child protection caseworkers and non-government staff to take part in the interviews.

The pilot study identified opportunities to better recognise and respond to the needs of children and young people exposed to domestic and family violence who come to the attention of a statutory child protection service.

The study identified the centrality of child-centred practice to effectively discover the needs of children and young people, as well as some of the challenges in identifying and referring children, young people and families to suitable services to meet these. The findings from cases that were commenced during the 2015–2016 period suggest several opportunities, including increasing the availability of child-centred, trauma-informed services, and strengthening the interagency working relationships to ensure these services are built into the work of CSOs. In particular, services focused on building and supporting attachment between non-offending/protective parents and children/young people exposed to domestic and family violence were not identified in the referral pathways we observed from that time period. Given that the quantitative (file) data identified being a young parent (those aged under 21) as a particular risk factor, there was little evidence from the interviews with caseworkers and the practitioners in the non-government services to which cases were referred of how this risk factor was being addressed through case management, and appropriate preventive strategies implemented.

While limited to data from a small retrospective sample of cases from within one Queensland child protection region, the legislative context, referral and service system capability, and data limitations were likely to exist in other areas of the state and possibly in jurisdictions across Australia. Overall, our pilot study demonstrated the value in investing time and resources in asking about and looking for evidence of child-centred therapeutic responses to the needs of children affected by domestic and family violence who come to the attention of statutory child protection authorities and identifying opportunities for system reform and improvements to pathways and nature of services to better address their needs.

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2. Introduction

Previous research has considered the needs of children in the context of specific service systems rather than as part of a broader system response to domestic and family violence (DFV) (Gordon, Higgins, McArthur, & Scott, 2018). To address this gap in evidence, the Australian Government Department of Social Services (DSS) commissioned Australian Catholic University's Institute of Child Protection Studies (ICPS) to undertake a project. The project was designed to develop, pilot, and test a methodology to explore child protection outcomes and service system referrals and responses associated with families where child protection concerns include DFV.

The pilot study analysed the characteristics of a small sample size of select children, young people and their families who were experiencing family violence, explored service responses (including the use of safety plans and other actions taken, such as referrals to programs or services), and gathered practitioner's perspectives on the appropriateness and effectiveness of service responses.

This project provides a picture of families in the child protection experiencing domestic and family violence issues, using a small sample of retrospective cases from a single region of Queensland and identifies opportunities and evidence designed to facilitate and improve collaboration and information sharing.

Queensland's Domestic and Family Violence Prevention Strategy 2016-2026 identifies domestic and family violence as "any behaviour that is physically, sexually, emotionally, psychologically, economically, spiritually and culturally abusive, threatening, coercive or aimed at controlling or dominating another person through fear" (Queensland Government, 2016a, p. 1).

Domestic and family violence occurs when one person in an intimate personal, family or informal carer relationship uses violence or abuse to maintain power and control over the other person. Broadly, under Queensland law, it includes behaviour that is physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive or aimed at controlling or dominating another person through fear. The violence or abuse can take many forms ranging from physical, emotional and sexual assault through to financial control, isolation from family and friends, threats of self-harm or harm to pets or loved ones, constant monitoring of whereabouts or stalking (Queensland Government, 2019).

Under the Domestic and Family Violence Protection Act 2012 (Qld), intimate personal relationships include married and defacto spouses; parents of a child; people who are, or were engaged; and people in couple relationships, including same-sex couples. Family relationships exist between two people who are related by either blood or marriage, including extended or kinship relationships where a person is regarded as a relative. Informal care relationships exist where one person is or was dependent on another person for help with essential daily tasks, such as dressing or grooming, meal preparation, grocery shopping or arranging medical care, where care is provided other than on a commercial basis (Queensland Government, 2019).

3. Background

In recent years, children and young people's exposure to family violence has become a prominent policy issue within Australia (Campo, 2015; Powell & Murray, 2008). The need to prevent and protect against the physical, sexual, emotional and psychological abuse of women and their children in their own homes has led to a range of policy reforms, research agendas, risk assessment tools, practice frameworks and funding for specialist family violence services across Australia (ANROWS, 2015). These responses reflect the increasing awareness of domestic and family violence and the acknowledgement of the significant number of children and young people exposed to family violence.

3.1 GOVERNMENT ACTION

The pilot study occurred against the backdrop of ongoing action by Commonwealth, state and territory governments to reduce violence against women and their children.

The National Plan to Reduce Violence against Women and their Children 2010–2022 (the National Plan; COAG, 2010) aims to connect the work of all Australian governments, community organisations and individuals to reduce violence. A key objective of the National Plan is to achieve an 'increase in the access to, and responsiveness of, services for victims/survivors of domestic and family violence and sexual assault'.

The National Framework for Protecting Australia's Children 2009-2020 (COAG, 2009) promotes a similar objective. It aims to explore the risk factors for child abuse and neglect and the intersections of family and domestic violence services with related systems, such as mental health, housing and child protection. Four separate 3-year Action Plans drive the fulfilment of the objectives of the National Plan and the National Framework. The plans identify actions, responsibilities and timeframes facilitating all governments to work together to develop, implement and report progress against the outcomes.

The Third Action Plan (2016–19) of the National Plan specifies that specialist and mainstream service provider capacity needs to be strengthened to better recognise and respond to the impacts of violence on children (COAG, 2016b). It also specifies that barriers to information sharing across jurisdictions should be addressed to develop a best-practice model of information exchange within and across government and non-government agencies where there are concerns about child well-being (Australian Department of Social Services, 2015).

The Council of Australian Governments (COAG) also established an advisory panel on reducing violence against women and their children. The panel recommended that integrated responses that mobilised the 'entire system' to ensure that complementary and seamless supports were delivered to children experiencing domestic and family violence. The advisory panel considered integration and collaboration as crucial to better assessment of risk, reduced fragmentation and duplication of service responses, improved efficiency and achievement of better outcomes for women and their children.

State and territory governments are also working to reduce violence. The Victorian Government's Royal Commission into Family Violence 2015-16 noted that children are 'frequently marginalised' in current responses to family violence and that there is a need for more (and more comprehensive) services specifically focusing on the needs of children and young people. The Royal Commission recommended stronger links between child protection, specialist family violence services and other service providers that respond to family violence (Victorian Government, 2016).

Victoria established Support and Safety Hubs, known as 'The Orange Door'. An Orange Door (or hub) helps women, young people, children and families access family violence services, and supports the well-being and development of children. The establishment of the hubs was a key recommendation of the Victorian Government Royal Commission and the Roadmap to Reform[1]. They are part of a long-term plan to end family violence in Victoria and help better support and protect vulnerable children (Victorian Government, 2015, 2016).

In recognition of the need for service integration, New South Wales (NSW) is rolling out 'Safer Pathway', with full implementation due in 2019. Safer Pathway provides guidelines on how child protection and domestic violence support services can work collaboratively and form partnerships that offer a continuum of services. The guidelines cover the assessment of risks to the child or young person and reporting to the NSW Department of Family and Community Services (FACS), assessment of the domestic violence threat to the adult victim/survivor, referrals to the Central Referral Point or a Local

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[1] Launched in April 2016, the 'Roadmap for Reform: strong families, safe children' details the Victorian Government's strategy for reform of the children, youth and family services system.

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Coordination Point, information sharing, coordination of service responses and collaboration with other services (NSW Government, 2014).

The NSW Domestic Violence Information Sharing Protocol supports the Safer Pathway guidelines. The protocol explains how information is shared in cases of family violence (NSW Department of Justice, 2014).

The Queensland Government established the Queensland Child Protection Commission of Inquiry (the Commission of Inquiry) in 2012. It reviewed whether the Queensland child protection system was best supporting vulnerable children and young people. The Commission of Inquiry identified that strong collaborative partnerships between the government and the non-government sector were needed to improve the child protection system.

There was also a Special Taskforce on Domestic and Family Violence established in Queensland in September 2014. The Taskforce examined Queensland's DFV support systems and made recommendations to the Premier on how the system could be improved and prevent future incidents of domestic violence. The final report, *Not Now, Not Ever*, provided suggestions on how to develop and deliver a model for integrated service responses (see Appendix 2).

Domestic Violence High Risk Teams (DVHRT) have been established in Queensland. These teams consist of officers from all agencies, including non-government, with a role in keeping victims safe and holding perpetrators to account, including police, health, corrections, housing and DFV services.

More recently (and since the period from which the cases for the current study were drawn), the Queensland Department of Child Safety, Youth and Women has also drawn on the Safe and Together Model (2017) and have trained workers and implemented this model across the state (see Appendix 2).

In addition, in 2018 new state-wide DFV Practice Leaders positions were created to further address DFV in the child protection system.

The effectiveness of the Family Law system in addressing issue of domestic and family violence has been considered in the course of several inquiries in recent years. The inquiries are: the House of Representatives Standing Committee on Social Policy and Legal Affairs Report - *A better family law system to support and protect those affected by family violence* (December 2017); the Family Law Council Report on Families with Complex Needs and the Intersection of the Family Law and Child Protection Systems (June 2016); and the Australian Law Reform Commission report *Family Law for the Future: an Inquiry into the Family Law System* (April 2019). Each have made recommendations for reform. As yet there has been no comprehensive or coordinated commitment or response from Australian Government, or from State and Territory governments to these inquiries or their recommendations. In September 2019 the Australian Government announced a further Parliamentary Inquiry into the Family Law System.

3.4 RESEARCH INSIGHTS

A literature review was carried out to provide context for the research in late 2017-18. In the review, we explored the intersection between child protection and family violence systems, including the identification of service gaps and access pathways (Gordon, Higgins, McArthur, & Scott, 2018). This section contains key excerpts from the literature review. These excerpts provide context for the findings of the pilot study. See Appendix 1 for the complete literature review.

3.5 IDENTIFYING DOMESTIC AND FAMILY VIOLENCE

A report to a statutory child protection department sometimes provides an opportunity for early intervention to support families at risk as well as the potential for preventing children's exposure to further violence (Campo et al., 2015). Yet there is a limited understanding as to what happens to

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children, young people and their families if they are reported to child protection with concerns of harm caused by exposure to family violence.

Domestic and family violence is not consistently acknowledged or recorded in child protection client databases. To the best of our knowledge, family violence is not captured systematically in child protection client databases throughout Australia, except for Victoria. In Queensland, family violence is not a standard data field in the Integrated Client Management System (ICMS), used by the Department to record child protection worker activity. Poor data capture about family violence has the potential to prevent or impede child protection services responses to cases involving DFV as they do not know the full extent and nature of the problem.

Problems can also arise if instances of DFV are not transparent in available data. Consistent with legislative grounds for intervention in each jurisdiction, 'witnessing family violence' is recorded as a type of emotional abuse in child protection client databases (Holzer & Bromfield, 2008). Including experiences of family violence within the category of emotional abuse is problematic. The consequence is that the nature and extent of experiences of family violence remains hidden. It is important to report DFV in ways that strengthen understandings of the characteristics of cases involving family violence, as well as the service system responses to these cases.

3.6 CHARACTERISTICS OF CASES INVOLVING DOMESTIC AND FAMILY VIOLENCE

In earlier international studies, cases involving DFV were substantiated more often compared with all other forms of child maltreatment and remained open for ongoing child protection services more often (Irwin & Waugh, 2007). Family violence was less likely to be rated low risk compared to other forms of maltreatment and more likely to be rated high risk (Irwin & Waugh, 2007).

Irwin and Waugh (2007) analysed thematically seventy-five cases involving family violence for referral pathways. More family violence cases were referred to community-based services compared with all other forms of maltreatment, with over half of family violence cases referred to services mostly for parent/family counselling and victim/survivor services for the victim/survivor parent (Irwin & Waugh, 2007). A complementary study noted the under-involvement of perpetrating fathers in investigation or for ongoing child protection services (Alaggia et al., 2015).

3.7 SERVICE RESPONSES TO DOMESTIC AND FAMILY VIOLENCE

Multi-agency collaboration – benefits, challenges, and opportunities

Children and families involved with the child protection system experience complex, interlinked problems that accumulate and reinforce negative outcomes. As a result of this, Australian and international researchers have increasingly called for a strong focus on improving how different systems can work together to increase children's safety (Buckley, Whelan, & Carr, 2011; Connolly, 2009; Hester, 2010; Humphreys, 2007; Stanley & Humphreys, 2014). Multi-agency collaboration that facilitates and provides better identification of risks, needs and service strategies is regarded as an important indicator of best practice for working with children and families affected by family violence (Humphreys & Absler, 2011).

Numerous studies have cited differences in the ideology and service delivery priorities held by child protection and family violence staff (Buckley et al., 2011; Davies & Krane, 2006; Fleck-Henderson, 2000; Potito et al., 2009; Rogers & Parkinson, 2017). Child protection agencies are government services that typically work with involuntary clients and have statutory authority and responsibility to do so. These agencies prioritise children's rights and safety through identifying and responding to risk (Fleck-Henderson, 2000). A child protection worker tends to view the separation of mother and child from the violent male perpetrator as the best solution and therefore may threaten the removal of children as a means of 'pushing' women to leave violent relationships (Hester, 2011).

Family violence agencies on the other hand tend to have no coercive power and disclosure is usually voluntary (Fleck-Henderson, 2000). The focus is on empowering women and ensuring the woman's safety (Buckley et al., 2011). They tend to view family violence as gender-based and rooted in gender inequality (Hester, 2011). Family violence workers therefore tend to place less emphasis on the mother being solely responsible for protecting her child, and more focus on the responsibility and tactics of the person who uses violence and the ways that family violence affects a mother's relationship with her children and her capacity to parent effectively (Zannettino & McLaren, 2014).

Key enablers and barriers to effective collaboration between child protection and specialist family violence services were apparent in a qualitative study conducted in South Australia (Zannettino & McLaren, 2014). Sixty participants completed a qualitative survey, which was followed by two focus groups with a mix of child protection and family violence workers (n = 30 and n = 20). The study found that family violence workers were more likely to consider the broader implications of family violence on children's emotional well-being than child protection workers. For example, the negative impact on the mother-child relationship and the potential for co-occurrence of other forms of abuse, such as physical abuse and neglect. The study suggested that both sectors could build on their common ground of concern for children's emotional and psychological well-being and incorporate practices that meet children's safety and therapeutic needs. Similarly, both services could more effectively work together to support the mother who has experienced violence and strengthen the mother-child relationship.

These ideological, structural and practice differences between the child protection and family violence sectors have created tensions that hinder collaboration (Potito et al., 2009). As a result, families' experiences with both sectors can be disconnected, ambiguous, and even confusing (Rogers & Parkinson, 2017). For example, a woman who discloses family violence to child protection services may experience blame (i.e., for having stayed in a violent relationship, thereby exposing the child to risk of harm) due to the workers' prioritisation of the child's safety. The workers may imply that the woman "failed to protect" her child, potentially isolating the woman from assistance and support (Potito et al., 2009; Rogers & Parkinson, 2017).

Despite the challenges in services working together, an integrated cross-sector approach is cited as best practice for working with children and families affected by domestic violence (Zannettino & McLaren, 2014). The integration of services is critical given that in case of domestic violence the safety of children is interwoven with that of the adult victim/survivor. The safety, welfare, and well-being of children and adult victims/survivors therefore needs to be considered in all decisions.

Research and practice wisdom highlight different opportunities to improve collaboration in the child protection and family violence sectors. Inter-professional training about the relationship between child protection and family violence is one approach (Stanley, Miller, Richardson Foster & Thomson, 2011; Szilassy, Carpenter, Patsios, & Hackett, 2013). A study conducted in England evaluated the outcomes of a short-course interagency training on family violence and safeguarding children. The study found that the training significantly improved knowledge and understanding of the role and responsibilities of professionals working in different organisations and increased the ability of professionals to recognise and identify signs of family violence (Szilassy et al., 2013).

The Barnardos Risk Assessment Matrix is a promising measure that considers both risks to women *and* children with thresholds for different forms of risk management and intervention. However, the matrix is yet to be rigorously evaluated (Stanley & Humphreys, 2014).

The PATRICIA (PAThways and Research in Collaborative Inter-Agency practice) project identified three domains that are critical to facilitating good collaborative practice. The domains are: integrated service focus, democratising practices, and partnership-supportive collaboration. The integrated service focus emphasises the importance of specialist expertise; including collaboration between child protection and specialist family violence services at a minimum. Collaboration may additionally include family support,

mental health, drug and alcohol, disability, Aboriginal or Torres Strait Islander services and Culturally and Linguistically Diverse (CALD) services (Humphreys, & Healey, 2017).

Inclusion of children and young people by Child Protection Practitioners in decision making

There is some evidence to show Australian child protection practitioners are committed to children's participation. A study with 467 child protection practitioners from five state jurisdictions in Australia investigated their practice responses and views on children's participation. The practitioners completed an online survey responding to case studies designed to determine the extent to which they would seek and include children's perspectives in decision making, and their confidence in talking to children. In contrast to the findings of other research, almost all workers reported that they would speak with a 5-year old child, would be confident doing so, and would give weight to the child's perspectives. The child's young age did not equate to low levels of confidence in consulting with the child and giving weight to their perspective. The research posited potential reasons for the difference in these findings compared with other research, including the experience of practitioners, increased child-centred policy in Australia, multiple understandings of participation, and variation in children and practitioner views of participation (Woodman, Roche, McArthur, & Moore, 2018).

Programs to support children and young people exposed to DFV

Empirically, there is little evidence to show whether interventions in the statutory child protection system are child-focused, trauma-informed, and address the needs of children exposed to domestic and family violence.

Yet research reveals that DFV recovery programs need to prioritise ways to strengthen the relationship between children/young people and their non-abusive or protective parent. Children and young people exposed to family violence who receive emotional support from the non-abusive or protective parent have improved outcomes (Smith et al., 2015). Given, the parent-child relationship can be strained through the experience of DFV, a key good-practice element of family abuse recovery programs is to strengthen this relationship. Based in the United Kingdom, the Domestic Abuse Recovering Together (DART) is a 10-week program that focusses specifically on strengthening the mother-child relationship after the abuse has ended and supporting other aspects of recovery. Mothers who participated in DART had significantly improved self-esteem, which was maintained six months post intervention. Children who participated in the program had a significantly greater reduction in their 'total difficulties' and 'conduct' problems than children in the comparison group (Smith et al., 2015).

Other research acknowledges the need for integrated therapeutic responses that address the needs of both the mother (or the non-offending parent) and child. Therapeutic responses to children exposed to DFV should include working with mothers (or the non-offending parent) and children to strengthen attachment and should be trauma-informed (Campo, 2015).

4. Project description

4.1 AIMS

Through this pilot study, we sought to understand the service system responses in one region (the South West[2]) in the Queensland statutory child protection service for children and families experiencing DFV when a report has been made to child protection authorities. The study aims were to:

- describe the characteristics of children and families reported to child protection services with issues of domestic and family violence

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[2] The South West region includes Ipswich North and South, Toowoomba North and South, Springfield, South Burnett and Roma.

- identify and map service responses including the use of safety plans and other actions taken including referrals; and

- make recommendations on how community-based and government services can better recognise and respond to violence.

This project provides more information about the nature of families and their interactions with child protection, family violence and family support services. A focus was the degree to which interventions were child-centred and addressed the needs of children exposed to DFV who had come to the attention of a statutory child protection service. Understanding what occurs in practice informs more effective collaboration and information sharing between the family law, family violence, child protection and family support systems.

4.2 APPROACH

To meet the aims, the project was conducted in four phases:

1. A focused literature review was carried out on research that assessed or described the intersection between child protection and family violence systems, including the identification of service gaps and access pathways, to provide context for the study.

2. A systematic retrospective case review of child protection files was conducted, along with quantitative analysis of data relating to children and families associated with child protection authorities.

3. Semi-structured qualitative interviews were conducted from March to June 2019, with a small sample of child protection practitioners and staff from non-government agencies to which families were referred to understand the nature of the interventions and processes for making referrals, evaluating risk and identifying the barriers and enablers to working across systems.

4. Synthesis of the data from the research activities to outline the findings of the pilot study and the effectiveness of the approach to illuminating what happens to the children and families reported to child protection with issues of domestic and family violence.

To complete phases 2 and 3, the study team approached child protection agencies in various jurisdictions to ascertain their interest in contributing to the pilot study (July 2017). The Queensland Department of Child Safety, Youth and Women agreed to be involved in the project and provided the study team with access to client records from its client database (known as the Integrated Client Management System; ICMS). The Department also agreed to the study team conducting in-depth interviews with a group of practitioners—both the Departmental (statutory) case worker (the "Child Safety Officer" or CSO), and an identified practitioner working in a non-government agency to which the family was referred.

4.3 EXTRACTING DATA FROM THE ICMS OF THE DEPARTMENT

Data were extracted from the ICMS of the Department to illustrate the characteristics of children and young people who experienced domestic and family violence. Extracts from the child protection files occurred in two stages.

The ACU Human Research Ethics Committee (HREC) (2017-210N) provided ethical clearance for the study. This was ratified by Monash University HREC (12226). To protect confidentiality of clients, the stage 1 data extraction processes (described directly below) ensured identifying information was not collected, and clients' identity remained anonymous to the researchers. For the stage 2 data extraction, the data were obtained in an aggregated form with data from all regions of the Department combined.

For Stage 3, interview participants were provided with detailed information about the study before consenting to participate.

Stage 1

Stage 1 involved a member of the study team gaining access to the ICMS. The team member underwent training in the ICMS and its content onsite. They were given 'in-confidence' access to the ICMS and a database of the full cohort of client files, for clients referred (notified) in the 2015-2016 financial year that were still open in February 2018 (*n* = 615). In mid-February 2018, a member of the ICPS study team extracted data for cases from the period 1 July 2015 – 31 December 2016.

The data extract contained client identifiers and requested variables that were already coded in the ICMS. Variables included the primary type of harm reported for the case, the source of referral (health/education/police etc.), ongoing intervention type, location, child age, gender, whether there were reports for siblings and ethnicity including being of Aboriginal or Torres Strait Islander descent. The study team conducted a systematic case file review to identify concerns about family violence in all the client files (*n* = 615). Family violence was then coded as current, historical, nil or not further specified, as well as the relationship between the child and the person who uses violence (perpetrator).

The initial data extraction process was undertaken in early 2018. Due to unforeseen errors in the data extraction and file matching and transfer process it resulted in the need for a second stage of data extraction. This occurred in early 2019. All stakeholders to the project agreed to this second stage.

Stage 2

In 2019, the Department provided several data tables (see section 4) to help illustrate key characteristics of the children, young people and families who had experienced domestic and family violence across Queensland. Although not specific to the South West Queensland region (where the cases for our qualitative interviews were drawn; see directly below), the data tables provide a picture of the intersection between DFV and child protection across the state of Queensland.

4.4 CONDUCTING QUALITATIVE INTERVIEWS

We conducted qualitative interviews from March to June 2019, with a small sample of CSOs and non-government practitioners to understand the nature of services and intervention pathways for children and their families reported to child protection with issues of domestic and family violence.

Identifying potential interviewees

Data were extracted from a case list supplied by the Department's data team. The list contained the same files originally extracted by Dr Scott in early 2018. A Research Officer from the Department viewed the stage 1 data extract and filtered the data via the sole location of the South-West Queensland Region. The Department identified this region because it included a mix of metropolitan, rural and regional locations. These locations include north and south Toowoomba, north and south Ipswich, South Burnet, Roma, and Springfield. The Departmental Research Officer applied a random selection formula in Microsoft Excel to select cases for discussion in interviews. The Departmental Research Officer then compared the child ID on the ICMS to confirm that the case was in the South West region, and extracted data using date of birth, CSO, Child Protection Order/or Intervention with Parental Agreement status. This dataset was then sent to ICPS via a secure file transfer.

ICPS received an initial list of 33 child protection cases from the South-West Queensland region. Of these, eight cases were excluded because the CSOs were no longer employed by the Department or were unavailable for interview, due to extended leave. ICPS lodged a request for more cases with the Department. A further 10 cases were supplied (bringing the total to 35 within-scope cases). Of the in-scope cases, two CSOs elected not to participate in the interview process and two did not respond to ICPS email and phones requests for interviews, resulting in 31 interviews.

Consent and interview processes

We commenced qualitative interviews with a small sample size of 31 CSOs. Three interviews were terminated when the interviewer identified that DFV did not form part of the case history. Twenty-eight interviews were completed in full. Upon completion of these 28 interviews, CSOs were asked to nominate a non-government service provider to which they had referred the child/family for services and who they thought would be able to speak to the issues being addressed in the case. Several CSOs were unable to provide a contact name or service due to no direct referral being made for the child, young person or the parents with whom they had worked.

Several CSOs were able to provide contact details for workers at non-government services. In total, they identified 10 agencies. At the request of the ICPS Research Officer, and in order not to breach confidentiality, CSOs contacted the non-government organisation in the first instance and requested their consent for the ICPS Research Officer to contact them about an interview. The CSO shared identifiable case information with the non-government worker so that the non-government worker knew which case the interview would explore, but the name and other identifiable information about the child and her/his family was kept confidential from ICPS. If consent was granted, CSOs sent a follow-up email to the non-government service, copying in the ICPS Research Officer. The ICPS Research Officer then contacted the service provider to seek their consent to participate and set up a date and a time for the interview. Of the 10 agencies identified, only a small number (7 non-government service providers) agreed to be interviewed.

Each CSO and non-government staff member was provided with a copy of the research project information sheet and a consent form (see Appendices 3 and 4). Each interview participant completed and returned the consent form prior to the interview. Each interview took approximately 15-30 minutes to complete and was recorded and transcribed (see Appendix 5 for the interview guides).

5. Findings from the Stage 2 quantitative data extract

Approximately 40% of households with a child protection notification had DFV identified as a risk factor for the years ending December 31, 2017 and 2018 (see Table 1). Other risk factors occurring in a high proportion of cases in households involved with the Department included a history of prior notification, mental health concerns, drug and alcohol abuse, criminal history and previous concerns of child abuse within the household. While not evident from Table 1, key research demonstrates that alcohol and drug use and past experience of violent victimisation are risk factors for DFV (Dunkley & Phillips, 2015).

Table 1. Proportion of cases involving family risk factors in all households involved with the Department

Family risk factors	Year ending 31 December 2017 *n* = 9,772	Year ending 31 December 2018 *n* = 10,016
Abused as a Child	39.7%	37.7%
Child Under 2 years of Age	33.9%	32.8%
Criminal History/Incarceration	46.1%	45.0%
Domestic and Family Violence	38.9%	40.0%
Drug and Alcohol	61.0%	59.3%
Four or More Children in Household	18.8%	19.3%
High/Complex Needs Children	17.3%	15.7%
History - Prior Notifications	70.2%	69.3%
History - Prior Ongoing Intervention	32.4%	31.7%
History - Prior Out of Home Care[3]	19.4%	19.0%
Housing/Homeless	4.5%	5.1%
Inappropriate Parental Attitudes and Behaviours	18.6%	16.4%
Mental Health	48.2%	46.5%

Physical Care Inconsistent with Childs Needs	8.8%	9.0%

Source: Queensland Department of Child Safety, Youth and Women

Notes:

1. Prevalence is measured as the proportion of households where the parent risk factor was identified in that household. Percentages sum to more than 100% as multiple risk factors could be identified.

2. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.

3. The family risk factor 'History - Prior Out of Home Care' was introduced as a Family Risk Evaluation question during the 2012-13 financial year. Where the department has previously placed any child from the household in out-of-home care prior to the current investigation and assessment. Includes any previous investigations and assessments during which a child from the household was removed from and placed outside the family home.

Consistent with other jurisdictions across Australia, Queensland has seen a rise in the number of families coming to the attention of statutory authorities where safety concerns relates to DFV (AIHW, 2019). In Queensland, there were 1,887 households represented in 2017 compared to 1,952 in 2018, see Table 2.

Emotional abuse was the most common type of harm substantiated in households where DFV was a risk factor across Queensland. Emotional abuse occurs when a child's social, emotional, cognitive or intellectual development is impaired or threatened. It can include emotional deprivation due to persistent exposure of a child to DFV. Emotional abuse most commonly occurs with other harm types (AIHW, 2019). The prevalence of emotional abuse, where DFV was a risk factor, increased from 74.2% (2017) to 76.6% (2018), see Table 2.

In households where DFV was **not** identified as a risk factor, neglect was the most common type of harm substantiated in both 2017 and 2018. Neglect occurs when a child's basic needs are not met, and their health and development are affected. The prevalence of neglect, where DFV was not a risk factor, was 57.3% in 2017 and 50.3% in 2018, see Table 2.

Table 2. Prevalence of harm types in substantiated households, by the risk factor domestic and family violence, Queensland

Was domestic and family violence a risk factor?	Harm type substantiated	Year ending 31 December 2017 _n_ = 3,919[1]	Year ending 31 December 2018 _n_ = 3,959[2]
Yes	Emotional	74.2%	76.6%
	Neglect	58.7%	51.6%
	Physical	39.8%	38.4%
	Sexual	4.4%	3.3%
No	Emotional	52.7%	50.3%
	Neglect	57.3%	52.7%
	Physical	32.9%	33.3%
	Sexual	11.9%	13.0%

Source: Queensland Department of Child Safety, Youth and Women

Notes:

1. DFV was identified as a risk factor in 1,887 households in 2017.

2. DFV was identified as a risk factor in 1,952 households in 2018.

3. Prevalence is measured as the proportion of households where the harm type was identified in that household.

4. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.

Non-Indigenous households in the system were more likely to have DFV as a risk factor. Approximately 60% of non-Indigenous households in the Queensland statutory child protection system had DFV as a risk factor compared with around 40% of Aboriginal and Torres Strait Islander households (see Table 3). These data are highlighted because Aboriginal and Torres Strait Islander children and young people are overrepresented in statutory child protection systems across the country. Therefore, the proportion of cases with the family risk factor of domestic and family violence by Aboriginal and Torres Strait Islander

status is noteworthy. In 2017 and 2018 there were considerably more non-Indigenous households with the risk factor of DFV than Aboriginal and Torres Strait Islander households.

Table 3 reveals small changes in the proportion of cases by Aboriginal and Torres Strait Islander status with the risk factor of DFV from 2017 to 2018. In 2018 there was a small increase in DFV as a risk factor in Aboriginal and Torres Strait Islander families (39.1% in 2017 to 40.6% in 2018) and a small decrease in DFV in non-Indigenous households (60.9% in 2017 to 59.4% in 2018).

Table 3. Proportion of cases with the family risk factor of domestic and family violence, by Aboriginal and Torres Strait Islander status, Queensland

Aboriginal and Torres Strait Islander status	Year ending 31 December 2017		Year ending 3x1 December 2018	
	n	*%*	*n*	*%*
Aboriginal and Torres Strait Islander Household[a]	1,488	39.1	1,624	40.6
Non-Aboriginal and Torres Strait Islander Household	2,316	60.9	2,380	59.4%
Total	**3,804**	**100%**	**4,004**	**100%**

Source: Queensland Department of Child Safety, Youth and Women
Notes:
1. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.
2. Percentages may not add to 100 per cent due to rounding.
(a) At least one parent or subject child in the household identified as Aboriginal or Torres Strait Islander.

DFV represented the highest immediate risk factor identified during the Department's safety assessment among young parents (14-19 years) in 2018 (Table 4). In 2018, 24% of young parents had a safety assessment identifying DFV as a risk factor compared to 14% of parents aged 20 or over. For the same year, the highest immediate harm indicator among parents aged 20+ years was drug and alcohol (experienced in 15.3% of households).

Table 4. Number and proportion of safety assessment risk factors, by the primary parents age, Queensland, year ending 31 December 2018

Safety assessment risk factor	Primary parent age			
	14 to 19 years		20+ years	
	n	*%*	*n*	*%*
Domestic and Family Violence	68	24.1	793	14.3
Drug and Alcohol	38	13.5	849	15.3
Emotional Harm	<5	<1	352	6.4
Escalating Threat	<5	<1	77	1.4
Failure to Protect	22	7.8	461	8.3
Inappropriate Parental Attitudes and Behaviours	19	6.7	307	5.5
Mental Health	46	16.3	627	11.3
Other Harm Identified	24	8.5	566	10.2
Physical Care Inconsistent with Child's Needs	39	13.8	836	15.1
Physical Harm	15	5.3	409	7.4
Sexual Abuse	7	2.5	263	4.7
Total	**282**	**100%**	**5,540**	**100%**

Source: Queensland Department of Child Safety, Youth and Women
Notes:
1. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.
2. Percentages may not add to 100 per cent due to rounding.
3. Please note that the table contains low cell counts which can be potentially identifying. As such, the data has been confidentialised.

There are regional differences in the identification of DFV as a risk factor in child protection cases. Table 5 identifies Moreton as the region with the highest proportion of cases where DFV was a risk factor (27.6%) in both 2017 and 2018. For the same period, the South West region (where the qualitative data comes from) had the lowest proportion cases with DFV identified as a risk factor. However, there was a rise from 14.6% in 2017 to 16% in 2018 in the South West region.

Table 5. Number and proportion of parent risk factor Domestic and Family Violence, by Region, Queensland

Region	Year ending 31 December 2017		Year ending 31 December 2018	
	n	%	*n*	%
Central Queensland	665	17.5%	575	14.4%
Moreton	1,050	27.6%	1,105	27.6%
Northern Queensland	818	21.5%	866	21.7%
South East	715	18.8%	810	20.3%
South West	556	14.6%	641	16.0%

Source: Queensland Department of Child Safety, Youth and Women
Notes:
1. Key centres included within each region:
   - Central Queensland: Rockhampton/Gladstone/Emerald, Maryborough/Bundaberg, Kingaroy
   - Moreton: Sunshine Coast/Gympie, Moreton Bay, Brisbane North, Brisbane South, Brisbane South West
   - Northern Queensland: Cairns, Cape York/Torres Strait, Townsville, Mackay, Mt Isa/Gulf
   - South East: Gold Coast Logan, Beenleigh/Bayside, Browns Plains/Beaudesert
   - South West: Toowoomba, Roma, Ipswich
2. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.
3. Percentages may not add to 100 per cent due to rounding.
4. The table contains low cell counts which can be potentially identifying. As such, the data has been confidentialised. Small cell count records assigned to 'Other' region (which can include units such as Child Safety After Hours Service Centre), 'investigation & assessment units' or a 'district office' are not itemized separately however are included in the totals.

The number of children living in a household does not appear to be a significant differentiating risk factor for DFV (Table 6). In 2018, 38% of households with DFV as a risk factor had four or more children living in them (compared to 62% where DFV was not identified as a risk factor). However, this result may be obscured by the fact that it is contemporaneous rather than retrospective data. More children may continue to be born into families that continue to come to the attention of the Department where DFV is also present. Given the high proportion of children from families where parents are very young (under age 20) with DFV as a risk factor, birth of further children is a stronger likelihood. This means that in the future, when looking at lifetime factors that affect child protection involvement, household size (number of children) may still end up being an important issue.

Table 6. Number and proportion of cases where four or more children are in a household, by parent risk factor domestic and family violence, Queensland.

Domestic and Family Violence risk factor	Year ending 31 December 2017		Year ending 31 December 2018	
	n	%	*n*	%
No	1,142	62.3%	1,201	62.0%
Yes	691	37.7%	735	38.0%
Total	**1,833**	**1100%**	**1,936**	**100%**

Source: Queensland Department of Child Safety, Youth and Women
Notes:
1. Households with a completed investigation and assessment in the reference period. If a household was subject to more than one investigation and assessment during the reference period, the household is counted for each instance.
2. Percentages may not add to 100 per cent due to rounding.

Service system responses to children and young people in the statutory child protection system who have experienced or witnessed family violence

6. Findings from the qualitative interviews

CSOs and practitioners at non-government agencies (service providers to whom the Department refer clients) shared their insights into what happened in a small sample of 28 cases where families reported to statutory child protection system were identified with issues of DFV. Findings from their interviews reveal details of the nature and type of DFV experienced by families and identify the service responses to DFV within the statutory child protection system. The nature of DFV in the cases reviewed related to intimate partner violence with the majority consisting of opposite-sex couples, one case identified a history of same-sex couple intimate partner violence. ICPS is aware of the other types of violence that can occur in a variety of settings and relationships, however this type of violence was not reported as part of the interview process and was not the scope of this project.

6.1 NATURE AND TYPE OF FAMILY VIOLENCE

All cases featured DFV as a historical or current area of risk in an intimate partner relationship or family dynamic. The domestic violence incidents included acts of violence between parent and parent, parent and child, and child and parent. In many cases it was women and children who were supported by the Department to leave violent and abusive relationships or to work with intensive family support services to address the violence occurring in their relationships and in the homes.

In addition to the DFV issues, many of the cases identified alcohol and drugs as a key issue of concern for one or both parents. There were cases where families were found to be 'cooking' ice (i.e., crystal methamphetamine) in the presence of their children. In one case, a father had been forcing the mother to use ice as a way of controlling her behaviour and keeping her within the relationship and prevent her leaving the family home. CSOs indicated that the ease of access to drugs and alcohol was a growing concern. On several occasions CSOs noted that the DFV in the relationships diminished once the parents sought help and were able to better manage their drug and alcohol usage.

6.2 SERVICE RESPONSES

Use of Departmental decision-making tools

No consistent or routine application of available departmental decision-making tools was evident. Several CSOs discussed their use of case-management tools (including safety plans and strength-based assessments) and how they had been used to inform case-management goals and planning. However, the majority of CSOs did not identify the application of these tools (even with direct prompting). This could also be due to the automatic nature of following practice guidelines and using the tools so automatically and consistently that they did not think to name and identify them during the interviews.

It is unclear why there was such seemingly poor uptake of decision-making tools in these cases from 2015-16. All the CSOs interviewed had not been involved with the family and/or child from when they first entered the child protection system. Often, they had to rely on the notes of their colleagues/predecessors to determine whether tools like safety plans and child/parent strength assessments had been conducted. Several CSOs seemed to experience difficulties navigating the ICMS to readily identify a full case history (including whether decision-making tools were used). Even so, none of the CSOs identified a need for them personally to use the decision-making tools. All appeared to rely on the assumption that these tools had been applied by their colleagues and applied in an appropriate way.

Information sharing

CSOs has different views on the appropriateness of the information-sharing arrangements from practitioners at non-government agencies. Typically, CSOs reported satisfaction with the information-sharing arrangements that existed between the Department and external service providers. However, NGO service providers were not always satisfied with existing arrangements. Many of the practitioners at non-government agencies we spoke to reported significant gaps in the information they had received from the CSOs. Service providers reported that they often did not receive complete case histories, which they felt hindered their ability to work effectively with children, young people and their families. They also lamented the lack of follow up and support from CSOs to fully identify a family history and referral needs. Some service providers indicated that it was sometimes difficult to contact CSOs via phone or email. Some linked the poor follow up and support to the turnover of CSOs.

CSOs and service providers across the South West regions, (where the Domestic Violence High Risk Teams (DVHRT)[3] have been progressively rolled out across the state since January 2017 through to 2019), have praised the information sharing resources. CSOs and non-government staff with practical experience, reported that the DVHRT had demonstrated effective collaborative practices.

Working with parents

Service responses typically focused on addressing the needs and concerns of parent(s), rather than explicitly focusing on the child/young person who was the target of the safety concern/notification. CSOs spoke confidently about the referrals they made to support services for parents. CSOs identified the needs of the mother or father, and the services that they required to address the child protection concerns.

Parents were referred to programs and services set up to address problem behaviours, like abusive actions and substance misuse, and/or support families experiencing vulnerabilities, such as homelessness. The intent was to initiate positive change processes in parents' behaviours and living circumstances in order to help them better nurture and safely care for their children:

> *Concerns were in relation to neglect, also, homelessness. No physical care of the children, and also mental health, substance issues, criminal history, and also, a history of the mother being in domestically violent relationships within the past year …. With the mom, there was some referrals. Also, with the father, they also wanted a referral to the [program name] domestic violence programs that they have for men. (CSO 19)*

> *… in relation to this family, it was what were the concerns, and what support the parents required to keep the children safe in the home. So, in relation to this case, the*

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[3] Domestic Violence High Risk Teams (DVHRT) form a core component of an integrated service response approach in Queensland. The DVHRT have been rolled out across 8 regions of Queensland. Early evaluation of the DVHRT highlight improvements in information sharing and enhanced accountability around service delivery across service agencies. The teams can secure faster and more targeted help for victim/survivors at imminent risk of lethality or serious harm. https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/our-progress/enhancing-service-responses/integrated-service-responses

mother needed to work with a DV service, a drug service, and also engage with a psychologist around her mental health, and a GP to provide for medication. (CSO 12)

… we focused on [what the] Child Safety [Department] said. Drug use and mental health were our two priorities. And so, we limited what we would focus on AODs [alcohol and other drugs] first and then moving into mental health [of the parents]. (Service provider 3)

Working with children and young people

Referrals expressly for services directly for children and young people seemed to be the exception. Although it was expected that there may have been referrals to child-centred services such as supported playgroups, child care, or other therapeutic services to address trauma or other needs of children and young people, this did not appear to be a strong theme from the practitioners we spoke to about cases from the 2015-16 period that were within scope. When asked specifically about referrals to support services for children and young people they made (as opposed to provision of supports for their parent/s), many CSOs found it difficult to provide an answer. Typically, they came back to the services offered to the parents and discussed how the parents accessing the services supported the needs of the children or young people in their care. Several CSOs appeared to find it difficult to identify referrals to meet the direct needs of the child or young person as distinct to those of their parents/carers.

A referral to a child-centred program or service was most likely in the group of cases involving older children/young people (i.e., individuals aged 12 years or over), even though many more cases in our sample of files related to children aged under 12 ($n = 24$) than for children aged 12 or over 12 ($n = 4$). Typically, these referrals sought to address school refusal and mental health concerns:

When I first got him, he had just been excluded from school, and we looked at other school and education options for him (aged 17 years). (CSO 6)

… we were involved with [three child and youth mental health services] … We tried other mental health places, like headspace, and then referrals, it was more to help those social skills for him (aged 17 years). (CSO 15)

So, there was family group counselling through the [program name] and [program name] was the individual counselling for the child (aged 12 years). (CSO 30)

When referrals were identified for children aged 0 to 11 years ($n = 24$) they were typically referrals to medical facilities. One child needed medical care for extensive burns. Other children were referred for more generalist care:

… he spent [6 months] in hospital. They were responsible for all care. Once he was discharged, they [the hospital staff] made referrals up to the hospitals here …He was referred to the burns clinic (aged 3 years). (CSO 23)

… obviously GP visits for… to keep their immunisations and vaccinations up to date, health check-ups… It also includes paediatrician visits when necessary, or consultations. (CSO 16)

A few CSOs suggested that the Intensive Family Support (IFS) services or Family Intervention Services (FIS) had provided support to the child/young person. The Intensive Family Support program based in Queensland is a consent-based or voluntary program (i.e., parents agree to participate) providing case management for families experiencing vulnerability with children and young people. The services are not specifically child-centred or youth-focused services. The CSOs did not elucidate whether or how a predominantly family-focused intervention services addressed the support needs of children and young people.

Only a few practitioners appeared alert to the lack of support provided directly to children and young people. One service provider suggested children and young people were not typically identified as 'clients' in their own right by the Department to avoid potential conflict with parents. This non-government worker felt that the reason CSOs sometimes failed to address the risks or needs of children and young people was in order to avoid alienating parents with whom they needed to work:

> *A sense from our service that some issues, some ongoing issues around the emotional and verbal abuses [of the children] probably, aren't really addressed or haven't really been addressed by CSOs probably for fear of escalating the parents. I think it is sort of unfortunate at times you get some of that stuff, sort of, I don't know, almost swept under that rug, that's sort of typical. [The Department] not wanting to, not wanting to raise it for fear of upsetting them [the parents] but I think the impacts, you can see that it does impact the children quite significantly. (Service provider 5)*

The lack of children's participation identified in this study contrasts with the findings of other research with child protection practitioners (see Woodman, Roche, McArthur, & Moore, 2018). While Woodman et al. (2018) found a positive view of children's participation in child protection, the findings of this study suggest little action by CSOs to consult children and give weight to their perspectives. Further research is needed to investigate potential reasons for low levels of children's participation identified from these cases from 2015-16. However, the child's age was not identified by CSOs as a factor. Key barriers included lack of specialist services, lack of in-house departmental expertise at that time, and poor client engagement (see section 6.3, below)

6.3 CHILD-CENTRED PRACTICE

While rare, our pilot study did uncover instances of child-centred practice. Of the 28 cases discussed in 35 interviews with CSOs and service providers, four illuminated a child-centred approach. Each of these cases involved children and young people aged 12 years and over.

The practice principles inductively identified from these four cases were:

- Open, regular communications with children and young people to build rapport

- Co-identification of needs and wishes with children and young people themselves

- Consistent involvement (or provision of opportunities for involvement) for children and young people in the case-management process.

These practice principles were consistently and comprehensively applied in the four cases. For the other 24 cases, the CSO or service **provider**, provided responses that suggested they had adopted some but not all principles. For instance, the worker might have appeared to communicate openly with a young person but did not identify instances of involving them in the case-management process.

This section details the applications of these principles and considers the enablers and barriers to child-centred practice, as revealed during the interviews. Text Box 1 provides a case example of what the child-centred approach involved for one young person.

TEXT BOX 1: ADOPTING A CHILD-CENTRED APPROACH

This case involved a 15-year-old young person, relinquished by both parents due to ongoing behavioural issues. These included risky criminal behaviour, physical abuse and violence towards siblings, exclusion and disengagement from education, and alcohol and substance use. There had been domestic violence in the parents' relationship.

The young person was placed on an interim care order, then a short-term child protection order. They transitioned out of care at age 17.

From the outset, the CSO worked directly with the young person to identify their needs and wishes - what they wanted to do. The young person was joined case meetings and case conferences and participated in referral processes.

The CSO supported the young person to identify and access support services to address their substance abuse and mental health concerns. The CSO worked with the young person to re-engage in an alternative education program. The CSO also frequently contacted the young person's carers (via phone and emails) to ensure open communication.

After moving to more suitable accommodation and joining a new peer group, the young person became more positive about their future. Their previous risky behaviours ceased.

The CSO consistently reinforced the need to engage the young person in all stages of the case planning and management processes. Involving the young person aided open communications and built trust between them and the CSO. The CSO worked to find out what the young person needed and wanted to be able to move forward. The young person openly chatted with the CSO about their concerns and needs. For instance, they talked about the substance use. The CSO and the young person identified a support service.

The young person engaged with the Child and Adolescent Mental Health Service at a local hospital. The CSO supported their attendance.

Prior to the young person leaving care, the CSO organised a referral to Next Step, an after-care service. The CSO also ensured the young person accessed the Transition into Independent Living Allowance (TILA). The CSO knew that the young person accessed the Next Step service, as they followed up with the worker in that service. The CSO also obtained additional brokerage funds to support the young person's longer-term housing arrangements.

The CSO identified that the young person would have access to the Department for further referrals and support up to the age of 25.

6.4 PRACTICE PRINCIPLES

Open, regular communication with children and young people

The CSOs and practitioners at non-government agencies highlighted the need for open, clear and regular communication with the child or young person. They described their efforts to build trust and rapport by taking time to listen to children and young about their lived experiences. When children were pre-language, practitioners used observation as a means of learning more about their needs:

> *I was **working for him** … so when I first started helping him, I think the biggest thing I found with him was that his peer group was all very much not going to school, going out doing drugs, drinking, getting into fights... My conversations with the young person and dad where he saw dad every now and again, but he felt like he couldn't really get along with his dad. Dad was, in his words, was a dickhead. He said that a lot of the time. (CSO 6, emphasis added)*

> *…when we were talking to him* [a child with who'd spent significant periods of time in foster and kinship care] *about what his views were around contact, he could clearly articulate some of his worries around strangers and people he didn't know or trust,*

and his mum letting them come into contact with him and being there when he was seeing his mother. That made him feel uncomfortable… (CSO 17)

[Following observation of the child] we are going through just around those developmental stages and what that looks like to … [gain] more of an understanding of where both kids are at. (Service provider 3)

Co-identification of needs and wishes

The CSOs identified the need to engage with children and young people to better understand what their needs were, from their perspective. They explained that this engagement needed to occur to help identify what would be the appropriate referrals and service supports:

Sitting down and talking to him about where his needs are, what he needs support with, and where does he feel he needs help with. Sitting down and talking to him about where does he want to do, where does he want to go... The process was really, I guess you could say really communication based, about having him involved and identifying where his needs are (CSO 6)

[Different teams within the service] have been able to keep really good communication and sort of just been getting updates on the case plans when we're with the client. (Service provider 5)

Involving children and young people in the case-management process

Child-centred practice for CSOs and practitioners at non-government agencies included consistent involvement (or opportunities for involvement) for children and young people in the case-management process. Their intent was to keep children and young people fully informed about decisions made about them, and encourage them to participate in decision-making processes:

It was very much getting him involved in that referral process...where does he want to go? ...For him, it was about really getting him involved in the meetings, because sometimes he just didn't want to go… really just wanting and getting him completely involved in the process and being at the meetings and aware of what's going on there. (CSO 6)

…we were having regular monthly stakeholders' meetings between the youth service, the early youth program and the CSO… That included our client and the parents and that was going really well, it sort of opened communication updates on how things were going... (Service provider 5)

One CSO acknowledged the importance of ensuring the case-management process proceeded in a manner and pace that suited their young clients. In their experience, children and young people could easily become overwhelmed with multiple referrals. Consequently, they described how they worked with their young client to identify "a few people, key people, that can work with them to work on their issues (CSO 23)."

6.5 ENABLING FACTORS

Information sharing was critical to effective case management. Most CSOs and practitioners at non-government agencies agreed that case management worked best when all stakeholders shared information with each other. Sharing information enabled all service providers to establish a consensus view on the risk and protective factors for families.

I think the biggest - the most important thing - is the sharing of information, and current information. And look, everybody's busy. But the key to providing that background service delivery is, I think, is for everybody to be on the same page. (Service provider 4)

For the child [aged 3 years] we have care team meetings. We did invite all the stakeholders and all the medical people to those meetings… making sure everything was in place for him. (CSO 23)

Information sharing in turn supported collaborative service responses. Access to information helped service providers to work together to deliver outcomes with and for families that were not easily achieved by working along. When identifying referrals, workers were also more alert to the possibility that service response options were either duplicated or missed:

*So, weekly home visits, that would be also with other agencies … we normally would talk to the other agency, like we were worried about this … **we'll need you guys to step up during intervention** [emphasis added]. (CSO 20)*

For the child we have care team meetings. We did invite all the stakeholders and all the medical people to those meetings. Monthly [meetings]. Some of them were fortnightly …It was quite intensive, making sure everything was in place for him. (CSO 23)

Multi-disciplinary teams were identified as a means of enabling information sharing and collaborative care. CSOs and service providers felt the DVHRT supported integrated service responses because the teams bought key stakeholders together, in one place. It facilitated 'wrap around' or holistic support for clients.

I think with us having the trial of the high risk domestic violence thing here in the Cherbourg area and connecting all areas now, and everybody getting together and being on the same page around what the violence is and how to protect a family, that has definitely been a positive that's come across in the last few months. (CSO 30)

6.6 BARRIERS

Poor communication and lack of information sharing

Practitioners at non-government agencies identified poor communication and lack of information sharing as barriers to child-centred practice. They felt that in some cases, that they did not receive all relevant case information upfront. Some expressed frustration with what they saw as a lack of communication from the Department. Some service providers described how they would sometimes find it difficult to contact the Department. Other providers reported making contact but then feeling that their service had not been provided with the full and complete case information:

Very limited in the information that I'm provided…. Yes, it's very limited. They're [the Department] not open sharing of information… [I sent] emails to the team leader in the middle of it, and she just kept saying she'll get her to phone, she'll get her to phone me. But the case worker just didn't phone. (Service provider 2)

Some practitioners at non-government agencies attributed the poor information sharing and lack of communication to the high turnover of CSOs. Practitioners spoke of cases that had involved several different CSOs. (This is consistent with what CSOs themselves told us: they often identified that they weren't the staff member who had conducted the initial risk assessment or had been involved when the case was opened.) Staff turnover and absences lead to delays while waiting for hand-overs to 'new' CSOs. Practitioners maintained that these delays negatively impacted on progress made with family, including children and young people:

You know I've just... one, two, three, four, five, six, seven, eight, nine, so at least nine separate CSOs have been involved in the family… Assisting the family in building good relationships with Child Safety [the Department], positive relationships – and definitely the family expressed numerous times it was hard. And then when they thought things were going positive it seemed like every time things start to get to

that stage, that CSO would leave or change teams and then get a new one and have to try and build up that trust again. (Service provider 2)

Both groups of professionals—the CSOs, and the practitioners at non-government agencies—acknowledged that poor communication and information sharing made it difficult to find responses that address client need. As one CSO explained: "unless we receive information from others, then it's very difficult for us to have a holistic understanding about what's happening."

Practitioners at non-government agencies discussed their concerns about miscommunication too. At times the Department had communicated to them case goals that were inconsistent with their observations of the strengths and vulnerabilities within a family. This miscommunication left practitioners uncertain as to their role (or purpose) in the case-management process:

I'm still waiting for child safety to actually direct us to what would they like me to do with mum and the children, what's my purpose of the family? … they've wanted to know how mum's partner's been doing in relationship with the kids. He's there but he doesn't engage much … The only way you can do that is by playing games with them …. And then the next time, he's already doing that. So, I feel like there's just a bit of miscommunication about what mum and child safety like, what needs work… you've [CSO] said she does really well – so why? What's my purpose? (Service provider 3)

Lack of specialist services and in-house departmental expertise

Lack of specialist services represented a significant barrier to child-centred practice. Several CSOs identified that specialised services for children and young people who have experienced DFV did not exist in their region at that time, or if they did, they had long wait lists. A few CSOs expressed concern that of those services that did exist, they were not age appropriate for a child or young person. Service providers also indicated that some of the available services had service inclusion requirements that meant referrals were only relevant in very particular circumstances.

… waiting list – when you do refer to other services, sometimes they have a long waiting list. Sometimes there are no other agencies in the area… (CSO 7)

Specifically… that child due to the young age, there's no ongoing support or etc., like that, because they're too young… (CSO 16)

… when we do use services like, you know child and mental health, they're usually an immediate response, so they have a response and a hospital response, but it isn't an ongoing service. (Service provider 1)

Some CSOs expressed concern about limited number of child-focused specialists within the Department. Often CSOs had to look to external agencies to support children and young people. This action contributed to the long wait times for the few suitable services.

The idea that as Child Safety, we don't employ occupational therapists. We don't employ speech therapists. We don't have any clinical staff that are immediately available to support, I think creates a big barrier. (CSO 17)

Poor client engagement

Representatives of both agencies shared concerns about working with families when the parent/s, child or young person choose not to engage or were uncontactable. Several CSOs and practitioners with non-government agencies discussed cases where clients were resistant to work with the Department or the Department had lost contact with them:

If I had more time with this family, or if I could get engagement with mum, there would have been services that I would have liked to have involved. But it's just I had very limited time and limited engagement, unfortunately. (CSO 5)

While CSOs and practitioners acknowledged that poor client engagement is typically a consequence of multiple factors (e.g., poor mental health, substance misuse, incarcerations, lack of transport etc.), they presented few solutions to poor client engagement. Their recall of the available case notes seemed to indicate that efforts were rarely made to follow up with disengaged clients. As one CSO explained, there is room for improvement in client follow up:

> *… he refused to engage with [service provider A] and refused to engage with parts of [service provider B), what we could have done better, on reflection, was having more regular visits, regular meetings, and just better communication between all parties. (CSO 15)*

KEY FINDINGS FROM QUALITATIVE DATA

- *Demonstrated principles of child-centred practice included:*
    - *Open, regular communications with children and young people*
    - *Co-identification of the child/young person's needs and wishes*
    - *Consistent involvement of the child/young person in all aspects of the case management process*
- *Information sharing and collaborative practice were key enablers of child-centred practice*
- *Barriers to child-centred practice included:*
    - *poor communication and information sharing*
    - *lack of specialist services*
    - *lack of experts for children and young people to work within the Department*
    - *poor client engagement*

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7. Conclusions and implications

The pilot study served two complementary purposes. It developed a method (or approach) for understanding service responses to children, young people, and families (from a small sample of retrospective cases) where child protection concerns occur within the context of DFV. In testing of this method, the study fulfilled its other aim of revealing insights into the nature of families' interactions with child protection and family violence and family support services, and the pathways of referral and service provision. This section concludes with directions for the future application of the study methodology and practice implications based on what was revealed about how government and non-government services were recognising and responding to violence at the time of these cases (drawn from cases that were opened in 2015-16, but remained open as at February 2018), particularly DFV experienced by children and young people in the statutory child protection system.

7.1 REFLECTIONS ON PILOT STUDY METHODOLOGY

The pilot study sought to analyse and learn from the wealth of data available within a long-standing client data system within the Queensland Department: ICMS. Even with the much-needed (and valued) support of the Department's data experts and CSOs the extraction of data from the ICMS posed challenges.

The initial identification of child protection cases involving DFV was difficult. The current ICMS does not include DFV as an individual indicator of concern in child protection cases. This is understandable to some extent, in that DFV is not a legislated harm type in Queensland (or in fact any other jurisdiction) to which statutory authorities have legislative authority to intervene (CFCA, 2019). However, the growing recognition of DFV as a feature of, or contributor to, child protection concerns suggest this is an issue to address. Anyone seeking to interrogate available data to identify instances of DFV in child protection

cases in Queensland is unable to search the ICMS for this risk factor. Resource-intensive processes are required to identify DFV in child protection cases.

Even when the cases were identified, it was not always easy to use the ICMS to learn historical details about these cases. Most CSOs found it difficult to navigate the ICMS to review earlier case notes and identify past decision-making processes. Consequently, the CSOs we interviewed were often only able to talk about their current involvement in a case. They could provide little to no information on historical information including the initial intake and assessment processes. The inability of CSOs to access (and convey) full case histories resulted in data gaps. This may also be due to the fact that we were asking CSOs to reflect on cases that were opened during an earlier period of time (1 July 2015 – 31 December 2016) when they may not have been actively involved in the case (noting however, that cases still had to be active/open at February 2018 in order to be within scope). In cases where there was staff turnover, not infrequent, we were asking them to respond to questions that related to the work undertaken by other CSOs. In several cases this made it difficult for the CSO we interviewed to interpret and review other CSOs notes and then provide accurate and current information.

One of the implications of our study is the opportunity to update or adapt the electronic client data system to address the difficulties we identified. CSOs need ready access to both current and historical case notes to inform their decision making. Managers and policy makers need ready access to evidence (collected via research projects like this one) on whether and how case-management processes support the best outcomes for children, parents and families. Ideally, the Queensland Government's funding commitment to improve the integrity of the child safety IT system and allow for greater information sharing between government and non-government organisations will also enable the readier collection of data on the efficacy of service responses in child protection cases involving DFV (Hendry, 2019).

The ICPS research team notes that the Department has recently established a 4-year program to implement a contemporary case and client management system to enable the best outcomes for children, young people and their families. This is called the Unify Program and it will be progressively implemented as a replacement for the current ICMS. At the heart of this program is the vision to implement a contemporary case and client management system that will enable the best outcomes for vulnerable children, young people, and their families (Queensland Government, 2019). For further information, see Appendix 2.

Securing the participation of CSOs in the study was a time-consuming exercise. It involved multiple phone calls and emails. Those CSOs able to respond to requests for interviews indicated that existing caseloads and work demands made it difficult for them to find time to contact the researcher.

To ensure the participation of CSOs in future research, several strategies may assist. As occurred on this study, the researcher needs the support of the Department and access to relevant data sets. Enough time is needed for the recruitment of CSOs (a lengthy process). Finally, CSOs could be provided with time release as required to participate in the research in a more meaningful way.

7.2 REFLECTIONS ON THE QUANTITATIVE AND QUALITATIVE FINDINGS

It was unclear whether departmental staff consistently use decision-making tools. Further research into their application (and the recording of their use within case-management data systems) may be warranted because the tools are designed to support the use of professional judgement and the consistent application of structured decision-making processes. Clients of the Department typically move through various teams, each performing a distinct role or function. Information obtained via decision-making tools needs to inform (and later provide the rationale for) key actions initiated by each of these teams.

Discussions with some CSOs revealed they were not always clear on what decisions were made, and how, or why a historical decision (like a referral to a service) was made for their client. Potentially this lack of understanding points to opportunities to improve the *application* of the decision-making tools,

the Department's internal information sharing processes, or both. Greater certainty in the value of decision-making tools and information sharing processes will help ensure needs-based decisions are made, and contribute towards quality outcomes for children, young people and their families. It is hoped that once fully implemented, the Unify Program (mentioned above) will address a number of these concerns with a more client-centric, needs-based response, data driven to enable and monitor outcomes approach. In addition, it is designed around collaboration and information sharing for better across government (Queensland Government, 2019). For further information, see Appendix 2.

The study revealed limited evidence of child-focused or child-centred approaches to the management of child protection cases involving DFV. Typically, CSOs and practitioners from non-government agencies focused on the needs of parents and rarely identified actions taken to directly support children and/or young people who had experienced family violence. Of the few practitioners (CSOs and NGOs) that practiced child-centred approaches, they often spoke about the importance of supporting young people. Their practice involved taking time to gain the trust of the young person, effectively communicating about their needs and wishes, working with other stakeholders to ensure the best outcomes for the young person and maximising the young people's participation in decision making.

Enabling the consistent application of child-centred approaches involves supporting workers to adopt the identified practice principles. As practitioners noted, there is a need to challenge existing ideas of CSOs and NGO service providers relating to when and how children and young people need support during case planning and ongoing case management. Further, there is an opportunity to improve communications about—and resources to support—the need to jointly deliver child-centred and parent-centred practice together (as opposed to one at the expense of the other). Training focused on 'why, when and how' to incorporate child-centred practices into everyday case-management processes will contribute to practice change. A review of available training would support an assessment of whether and how current offerings are providing suitable opportunities for all staff to learn about child-centred practice, in keeping with the intent of child protection legislation across Australia.

The cultural change required to see the consistent adoption of child-centred practice, however, will require more than training. The Department and service providers would need to adopt plans and strategies to ensure child-centred practice becomes a reality in all cases, not just those involving DFV. Management must support child-centred practice in words and actions. Mentoring can help practitioners learn and change. New or revised processes and procedures (e.g., established referral pathways for children and young people as clients in their own right) may also be required.

There is a lack of specialist service providers for children and young people in many of the locations which took part in the study. While most CSOs could identify available services, these were not typically designed explicitly for children and young people. Of the predominantly adult-focused services that were available most had long wait lists. Many of these services also had service inclusion requirements. When these requirements were not met, NGO service providers felt they had to take on roles and responsibilities that ideally should have rested with the Department. Further funding to support regional evidence-informed services is important. (For examples of such services, see Barker et al., 2013). Co-design workshops where both government and non-government child protection practitioners could be used to identify service gaps and how to best address them to ensure the most effective approach to service provision for families experiencing DFV.

Consistent with previous research, our findings also revealed issues with case management practices (Gordon, 2018). Departmental decision-making tools appeared to be inconsistently applied, information sharing between stakeholders was often limited, and service provides found follow-ups with CSOs difficult. Client-focused care depends on effective information sharing and stakeholder collaboration. It appears that staff would benefit from further training, and specific tools that enable information sharing and collaboration—both internally (when cases are handed on from one CSO to the another; and externally—with NGO service providers to whom referrals are made.

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7.3 IMPLICATIONS

Although the pilot data we reported here was from Queensland using a retrospective design and was from a small sample of cases, it is likely to be applicable nationally. All departments with responsibility for child safety have struggled or continue to struggle with the adequacy of client data systems – and the prohibitive cost of upgrading. Social work journals attest to the common problems across Australia—and in fact internationally—of case management, interagency cooperation and communication in statutory child protection work. It goes beyond statutory work to broader human service delivery (Stewart, Lohoar, & Higgins, 2011).

The pilot study identified the centrality of child-centred practice to effectively uncover the needs of children and young people exposed to DFV who come to the attention of a statutory child protection service. It also identified several challenges to its implementation. Child-centred practice is an issue gaining traction across different areas of child welfare. But there are challenges to its implementation in statutory child protection work (Hunter & Price-Robertson, 2014). These will need to be explored within different contexts, and the obstacles and constraints considered if the principles are to genuinely be embedded throughout the assessment, planning, and ongoing referral and management of child protection cases.

There are some issues that were raised in the literature search that were not raised by practitioners throughout the interviews for this pilot study. In particular, the following two issues stand out:

- the need for strategies and therapeutic services to build and support attachment between non-offending/protective parents and children/young people exposed to DFV; and

- the value of trauma-informed, as well as child-centred practices.

Given that these issues are well identified in the broader literature on DFV (e.g., Hooker, Toone, Raykar, Humphreys, Morris, Westrupp, & Taft, 2019) and child welfare (Wall, Higgins, & Hunter, 2016), exploring how they can be built into the work of CSOs—and the services to which they refer clients—is an important opportunity.

Finally, one of the clearest risk factors for DFV identified in the Queensland-wide quantitative data was that of being a young parent (those aged under 21). Again, there was little evidence we found from the qualitative interviews with CSOs and the practitioners in the non-government services to which cases were referred of how this risk factor was being addressed through case management. Given their age, there is a strong likelihood of further pregnancies and therefore of ongoing involvement of the statutory service in their family life to ensure the safety of subsequent children. Preventive strategies, and in particular therapeutic interventions that understand the personal vulnerabilities and relationship issues that led to the initial teen pregnancy, were issues that were not raised in our study. This suggests an important opportunity to address the potential ongoing effect of this risk factor and its potential for interrupting an intergenerational cycle of vulnerability and child protection involvement.

Our pilot study demonstrated the value in asking about and looking for evidence of child-centred therapeutic responses to the needs of children affected by DFV who come to the attention of statutory child protection authorities. Our data suggest there are challenges to address including process around information sharing and collaborative practice between statutory workers and those in services to whom they referred families. In looking at the role of child-centred practice within statutory child protection work with those who have been exposed to DFV, some of the barriers to child-centred practice we found were: poor communication and information sharing; difficulty in accessing appropriate expertise internally within the department, and a lack of external specialist services to refer to. In this context, it is also not surprising that poor client engagement was identified as an issue. This raises the issue of the context of trying to deliver supportive, therapeutic services within a mandatory context (Higgins, Lonne, Herrenkohl, & Scott, 2019).

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Despite data limitations and challenges in identifying cases, we were able to find evidence of good practice. Positive examples were found that demonstrated open, regular communications with children and young people; co-identification of the child/young person's needs and wishes; and consistent involvement of the child/young person in all aspects of the case management process. Trauma-informed therapeutic responses that build attachment to non-offending parents/caregivers and address the personal/relationship and structural risks of early parenthood are opportunities for strengthening and embedding child-centred and preventive interventions to respond and heal from exposure to DFV.

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Appendix 1 - Focussed literature review

Child protection interventions: statutory responses for children experiencing family violence

For this review, the term 'family violence' is used throughout for consistency, however it should be noted that some of the studies specifically referred to 'domestic violence', 'intimate partner violence', or 'domestic and family violence'.

Profile of children exposed to family violence

In Australia, family violence is one of the most common reasons for generating a report to child protection authorities (Potito, Day, Carson, & O'Leary, 2009). Of the 45 714 substantiated reports across Australian states and territories in 2015-2016, 20 339 were for emotional abuse (AIHW, 2017). This high proportion of substantiations for emotional abuse is relatively recent, and is largely attributed to the inclusion of witnessing family violence within this category (Holzer & Bromfield, 2008). Witnessing family violence is now considered a form of maltreatment (often captured as emotional abuse), due to its detrimental impact on children (AIFS, 1997).

Children living in homes where there is family violence are at risk for being physically and/or sexually abused (Davies & Krane, 2006; Potito et al., 2009), as well as experiencing psychological harm such as post-traumatic stress disorder, depression, and emotional and behavioural difficulties (Smith, Belton, Barnard, Fisher, & Taylor, 2015). Between 2007 and 2012, of the 768 children known to Community Services who died, 61 percent of these children were in homes where family violence was present (NSW Government, 2012). This data mirrors international data; in England for example, family violence was a common factor in cases of serious and fatal child maltreatment (Sidebotham et al., 2016). Child abuse and family violence therefore often overlap and coexist, with the presence of one flagging concerns for the other (Davies & Krane, 2006; Jones, 2007).

Service responses and access pathways

Child protection responses

The three national and four international studies below examine child protection service responses for cases with a concern about family violence. The studies differed in the variables examined, limiting the ability to make comparisons between studies. Three of the studies examined the classification/severity of the cases (Alaggia, Gadalla, Shlonsky, Jenney, & Daciuk, 2015; Irwin & Waugh, 2007; Jones, 2007), five of the studies examined the features/demographic characteristics of clients (however differed in the features/demographic features of focus) (Alaggia et al., 2015; Jones, 2007; Lee, Lightfoot, & Edleson, 2008; NSW Government, 2012; Schlonsky, Ma, Katz, Humphreys, & Healy, 2017), three of the studies examined the types of interventions/services received (Alaggia et al., 2015; Black, Trocme, Fallon, & MacLaurin, 2008; Jones, 2007), and two examined referral pathways (Alaggia et al., 2015; Jones, 2007) (See Table 1 for a summary of key findings).

National literature

An Australian study analysed responses of the statutory child protection authority in NSW to abuse allegations involving family violence over an 18-month period. Results found that family violence was the most common reason for referral (26% of the 431 referrals), however a higher percentage of family violence referrals were recorded as *information only* (deemed not serious with no further action taken) compared to other referrals. Although a similar percentage of family violence cases were recorded as *notifications* (serious with need for follow-up) compared to other cases, a smaller number of family violence cases were followed up with an investigative assessment. Further, while a higher percentage of family violence cases were confirmed, significantly less were recorded as *registered cases,* which receive ongoing response from statutory child protection workers. A similar pattern was seen in the re-referrals, with family violence re-referrals less likely to be further investigated. Overall, the study highlighted that family violence was either not considered a child protection issue or was considered less serious than other forms of abuse or neglect (Irwin & Waugh, 2007).

Another study conducted in NSW analysed the cases of the 466 children who died and who were reported for family violence in the period between 2007 and 2012 (NSW Government, 2012). Case analysis found that there were higher levels of other reported abuse types (i.e. physical abuse, emotional abuse, supervisory neglect, physical neglect, medical neglect, sexual abuse) in the 466 cases compared to the 302 children who died but who did not have a reported history of family violence. The families who had been reported with concerns about family violence had higher levels of substance misuse, mental health problems, poverty, transience and homelessness, compared to the families without reported concerns about family violence. A higher percentage of the children were also Aboriginal and/or Torres Strait Islander; 32% compared to 15%. The study concluded that there is a need for child protection interventions that address multiple risk factors.

In the PATRICIA (**PAT**hways and **R**esearch **I**n **C**ollaborative **I**nter-**A**gency practice) Project, longitudinal record data (from years 2010-2015) from the child protection systems in NSW, Victoria (Vic), and Western Australia (WA) were analysed. Differences in recording practices between the states limited the number of indicators that could be used for comparison (for example, in Victoria only police reports to child protection were included due to the way in which Victoria identifies cases involving family violence; family violence can be identified as a concern at any stage during a child's involvement with child protection in Victoria and it was unclear at which point family violence was identified in the data). The study found that there was an increase in child protection reports across all states from 2010-2014. In NSW and WA, family violence was often paired with another maltreatment concern, with emotional abuse being the most common followed by physical abuse. Across the three states, about half of the children reported for concerns involving domestic violence were aged five and under, almost 30% had previous involvement in the child protection system, and Aboriginal and Torres Strait Islander children were overrepresented (16% compared to 4% in the general population) (Schlonsky et al., 2017).

Across the three states, children reported for family violence (29%) were slightly less likely to be investigated in 12 months than children reported for other concerns (34%). Similarly, children with reports involving family violence were slightly less likely to be placed in out-of-home-care (OOHC) following an investigation than children reported for other concerns. There were no major differences in the rates of re-report between children initially reported for family violence and children reported for other concerns. The study concluded that family violence did not have a large influence on how children progress through the child protection system when compared with other factors including age, previous history with child protection or placement in OOHC, and/or if they are Aboriginal or Torres Strait Islander. The study outlined key implications including the need to treat maltreatment concerns differently depending on what is known to work with each type. The study also emphasised the need for improved data communication between police, child protection and family systems (Schlonsky et al., 2017).

International literature

A Canadian study examined differences in family violence-involved cases and other forms of maltreatment on child protection caseloads (n = 785) over a 4-month period. Of these investigations, 26% cases were family violence referred and 87% of the family violence victims/survivors were mothers. The family violence cases differed from other forms of child maltreatment in numerous ways. Family violence cases were more often referred by police, the families were younger, as were the child victims/survivors, and significantly more non-white families were investigated for family violence than white families (Alaggia et al., 2015). In contrast to the aforementioned Australian study (Irwin & Waugh, 2007), family violence-involved cases were substantiated more often compared with all other forms of child maltreatment (p < 0.001), and remained open for ongoing child protection services more often (p < 0.001). Family violence was less likely to be rated low risk compared to other forms of maltreatment (p < 0.001) and more likely to be rated high risk. Seventy-five cases were thematically analysed for referral pathways. More family violence cases were referred to community-based services compared with all other forms of maltreatment; over half of family violence cases were referred to services mostly for parent/family counselling and victims/survivor services for the victim/survivor parent. An identified gap the study identified was the under-involvement of perpetrating fathers in investigation or for ongoing child protection services (Alaggia et al., 2015).

A US study recruited a sample of 107 women from family violence service agencies. Among the 30% who were involved in child protection services, referrals were more likely when the family violence perpetrator was *not* the biological father (75%, χ^2 = 7.95, p= .005) (Lee et al., 2008). This finding is consistent with findings from other studies e.g. (Radhakrishna, Bou-Saada, Hunter, Catellier, & Kotch, 2001), however is contrary to the evidence that serious or fatal child abuse is more likely to be perpetrated by a child's biological father than by a mother's boyfriend (Lee et al., 2008). Another US study randomly selected 445 children from a protective service population in California, of whom 43% came from families with an indication of family violence. The study examined the most common interventions or outcomes recorded by the child protection workers for the domestic violence cases.

The most frequently recorded intervention was for the workers to have a discussion with the parent about the dangers of a child viewing family violence, followed by police involvement, provision of mental health services and the safety intervention of urging the use of courts and restraining orders. It was unclear whether police involvement was due to the child protection worker calling the police, or the police calling the child protection worker. Another key finding was that women who did not go to shelters were five times more likely to receive a new referral to child protection than women who did. Overall, families in which family violence occurred experienced greater complexities including substance abuse, a charged criminal history, and a chronic medical problem (Jones, 2007).

A Canadian study found that children brought to the attention of child protection services for exposure to family violence were less likely to be removed from their home compared to children experiencing other forms of maltreatment. However, when exposure to family violence coexisted with other forms of maltreatment there was a high likelihood of the child being removed (Black et al., 2008). While in practice separation is often viewed as the primary means of ensuring the child's safety, research indicates that it actually increases the risk of homicide and serious sexual and physical assault when there has been a history of family violence (Humphreys, 2007).

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Table 1. Summary of studies examining child protection responses for cases with a FV flag

Study	Study location	Is FV identified as a category of harm?	Initial response to FV flag	Key referral (e.g., police)	Type of services family violence (FV) cases referred to (e.g., parent/family counseling); placement in Out of Home Care (OOHC)	Prevalence of broader problems/complexity in the lives of families where FV is present
Alaggia et al. (2015)	Ontario, Canada	Yes.	FV more likely to be rated as high risk compared to other cases ($p < 0.001$)	Police 50%, family or friends 16%, mental-health worker 14%, school 11%, health-care worker 7%	Over half of FV cases referred to services for parent/family counselling and victims/survivor services for the victim parent	Not indicated
(Black et al., 2008)	Canada-wide	Yes.	Severity not indicated, however in most FV cases it was noted that there was no emotional harm to the child (88% in FV only cases & 69% in co-occurring exposure to FV)	Not indicated	Services not indicated; 10% of co-occurring exposure to FV & 2% of FV only placed in OOHC, vs 10% other child maltreatment; 14% of co-occurring exposure & 2% of FV only referred to child welfare court, vs 8% other child maltreatment	26% of substantiated FV cases co-occurred with another form of maltreatment
Irwin and Waugh (2007)	NSW, Australia	Yes.	Assessed as less serious than other forms of abuse (e.g. 13% FV referrals vs. 7% other referrals deemed low risk)	Not indicated	Not indicated	Not indicated
Jones (2007)	California, US	Unclear. FV identified through 1 of 3 ways: (1) Caretaker received services or referral for FV (2) Caretaker self-reported being victim of FV (3) Another professional indicated	41% of cases classified as severe (coding appears to have been completed by the researchers for the study, rather than the caseworkers)	Unclear whether police involvement was due to the CP worker calling the police, or the police calling the CP worker	Most frequent intervention was mandating court (53%), followed by counselling the parent to protect the child (50%), police involvement (50%), & provision of mental health services (43%) Services not indicated; 47% had a child removed, but 50% of those cases the child was returned home	High prevalence of broader problems in families, including (for the biological mother) drug abuse (61%), alcohol abuse (48%) a charged criminal history (36%), incarceration (14%), & a chronic medical problem (14%)

Study	Study location	Is FV identified as a category of harm?	Initial response to FV flag	Key referral (e.g., police)	Type of services family violence (FV) cases referred to (e.g., parent/family counseling); placement in Out of Home Care (OOHC)	Prevalence of broader problems/complexity in the lives of families where FV is present
		caretaker victim of FV.				
Lee et al. (2008)	Dallas, Minneapolis, San Jose and Pittsburgh, US	Not applicable - recruited from FV services (rather than CP)	Not applicable	Not applicable	Not applicable	Not indicated
NSW Government (2012)	NSW	Yes, however analysis based on reported child deaths, comparing those with FV flag to those without	Not applicable	Not applicable	Not applicable	Higher prevalence of broader problems in family, including parental substance abuse (66% in cases with FV flag vs 29% in cases without FV flag), at least one parent with mental health (40% vs 19%), families in poverty (23% vs 9%), homelessness (22% vs 9%), & transient families (21% vs 8%).
Schlonsky et al. (2017)	NSW, Vic & WA, Australia	Yes. In Vic unclear at which point FV is identified in the data	Assessed as less serious than other forms of abuse (29% FV cases investigated in 12 months vs 34% other concerns)	Not indicated	Services not indicated; children with FV flags slightly less likely to be placed in OOHC	In NSW and WA, FV often paired with another maltreatment concern; emotional abuse most common followed by physical abuse (13% of NSW reports and 18% of WA reports for FV and other concerns, vs. 3% & 9%, respectively, for FV only) Vic data unable to be provided.
OOHC: Out-of-home-care; CP: child protection; FV: family violence						

Collaboration between the child protection and family violence sectors

Numerous studies have cited differences in the ideology and service delivery priorities held by child protection and family violence staff (Buckley, Whelan, & Carr, 2011; Davies & Krane, 2006; Fleck-Henderson, 2000; Potito et al., 2009; Rogers & Parkinson, 2017). Child protection agencies are government services that typically work with involuntary clients and have coercive power and the ability to involve the court if necessary. The agencies are child-focused and prioritise children's rights and safety through eradicating risk (Fleck-Henderson, 2000). A child protection worker tends to view the separation of mother and child from the violent male perpetrator as the best solution and therefore may threaten the removal of children as a means of 'pushing' women to leave violent relationships (Hester, 2011).

Family violence agencies on the other hand tend to be grassroots and democratic, disclosure is usually voluntary and the services have no coercive power (Fleck-Henderson, 2000). The focus is on empowering women and ensuring the woman's safety (Buckley et al., 2011); they tend to view family violence as gender-based and rooted in gender-equality (Hester, 2011). Family violence workers therefore tend to place less emphasis on the mother being solely responsible for protecting her child, and more focused on the responsibility and tactics of the perpetrator and the ways that family violence affects a mother's relationship with her children and her capacity to parent effectively (Zannettino & McLaren, 2014).

These ideological and structural differences between the child protection and family violence sectors have created tensions that hinder collaboration (Potito et al., 2009). As a result, families' experience with both sectors can be disconnected, ambiguous, and even confusing (Rogers & Parkinson, 2017). For example, a woman who discloses family violence to child protection services may experience blaming because of the workers' child-centred focus. The workers may imply that the woman "failed to protect" her child, potentially isolating the woman from assistance and support (Potito et al., 2009; Rogers & Parkinson, 2017). Despite the challenges in services working together, an integrated cross-sector approach is cited as best practice for working with children and families affected by domestic violence (Zannettino & McLaren, 2014).

The integration of services is critical given that the safety of children is interwoven with that of the adult victim. The safety, welfare and well-being of children and adult victims/survivors therefore needs to be considered in all decisions. In recognition of these needs, NSW is rolling out Safer Pathway, with full implementation due to be completed in 2019. Safer Pathway provides guidelines on how child protection and domestic violence support services can work collaboratively and form partnerships that offer a continuum of services. The guidelines relate to the assessment of risks to the child or young people and reporting to FACS, assessing the domestic violence threat to the adult victim and making referrals to the Central Referral Point or a Local Coordination Point, sharing information, coordinating a service response, and collaborating with other services (NSW_Government, 2014). One of the supporting documents is the NSW *Domestic Violence Information Sharing Protocol,* which explains how information is shared in cases of family violence (NSW_Department_of_Justice, 2014).

Collaboration between the police and child protection system

A UK study analysed 251 police records of incidents of domestic violence in two local authorities in England (Stanley, Miller, Richardson Foster, & Thomson, 2011). The study found that limited information was provided on previous incidents or details relating to children's involvement in incidents. Slightly over half of the incidents were classified as low risk (verbal argument without violence or aggression), more than one fifth were classified as medium risk (verbal abuse with some physical abuse, without any injuries being sustained), and just over a quarter were allocated to high risk (verbal abuse with physical injury inflicted, a high level of violence or a verbal argument with threats to kill). When the police notification forms were matched up with social work records, discrepancies in the identifying details for children and families were found in 40% of notifications.

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The NSW Domestic Violence Death Review Team provided a list of recommendations in their 2012-2013 Annual Report to reduce the incidence of family violence. One of their recommendations related to greater collaboration between the NSW Police Force and the child protection system through a policy amendment. It was suggested that the policy is amended to require police to notify FACS of any known biological or non-biological surviving children of the deceased or perpetrator (including children who may not be ordinarily resident with the deceased or perpetrator). Once a notification is made, FACS should co-ordinate with agencies including DEC and Victims Services to ensure that counselling and services appropriate to the specific trauma experience, age and geographic location of the child/ren is made available to those children in a timely fashion. Victims Services, DEC and FACS should co-ordinate to develop a strategy and develop additional support services tailored for this group of child victims/survivors, in cases where their families or carers are reluctant to engage with counselling and support services (NSW_Government_Attorney_General_&_Justice, 2015).

Collaboration between the family law and child protection system

Two procedural and legal reforms introduced in Australia in response to the growing number of family violence matters are specialist family violence courts and the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011.*

A Family Violence Court Division (FVCD) was introduced in Victoria in 2005 to provide an integrated and specialist response to FV. The FVCD has since been rolled out across selected courts in Victoria. The division is therapeutically focused, with the aim of responding to the needs of vulnerable women and children and reducing recidivism. Depending on the nature of the offence, the judge may refer the perpetrator to a men's behaviour change program, community work, judicial monitoring or imprisonment (Hawkins & Broughton, 2016). While the FVCD meets several 'best practice' elements for FV courts, including specialist personnel and holistic, therapeutically based support services, it is currently limited by inadequate resourcing that does not meet the overwhelming demand (Lauritsen & Chambers, 2015). Specialist family violence courts also operate in NSW, Queensland, South Australia, Western Australia and the Australian Capital Territory, however they differ significantly in their degree of specialisation and operational features (Australian_Law_Reform_Commission, no date).

In 2012 the *Family Violence and Other Measures Act 2011* was brought into effect. The amendments aimed to improve the family law system's screening of, and response to, family violence and child abuse. Key elements included broadening the definition of family violence and abuse in relation to the child and placing greater weight on the protection of children from harm. A mixed-method evaluation, conducted two years after the amendments were implemented, found that the amendments had a greater influence on identification and screening practices than on patterns of parenting arrangements. For example, there was a statistically significant increase in the proportion of parents reporting that they had been asked about family violence and safety concerns when using a formal family law pathway to resolve their parenting arrangements. Similarly, there was a small but statistically significant increase in the number of parents who reported experiencing family violence to a service (Carson et al., 2016).

Solutions for achieving collaboration between sectors

A qualitative study conducted in South Australia examined the enablers and barriers to effective collaboration between child protection and specialist family violence services (Zannettino & McLaren, 2014). Sixty participants completed a qualitative survey, which was followed by two focus groups with a mix of child protection and family violence workers (n = 30 and n = 20). The study found that family violence workers were more likely to consider the broader implications of family violence on children's emotional wellbeing than child protection workers. For example, the negative impact on the mother-child relationship and the potential for co-occurrence of other forms of abuse, such as physical abuse and neglect. The study suggested that both sectors could build on their common ground of concern for children's emotional and psychological well-being and incorporate practices that meet

children's safety and therapeutic needs. Similarly, both services could more effectively work together to support the abused mother and strengthen the mother-child relationship.

Inter-professional training about the relationship between child protection and domestic violence is one approach that is advocated in the literature (Stanley et al., 2011; Szilassy, Carpenter, Patsios, & Hackett, 2013). A study conducted in England evaluated the outcomes of a short-course interagency training on domestic violence and safeguarding children. The study found that the training significantly improved knowledge and understanding of the role and responsibilities of professionals working in different organisations, and increased the ability of professionals to recognize and identify signs of domestic violence (Szilassy et al., 2013). Additionally, the Barnardo's Risk Assessment Matrix is a promising measure that considers both risks to women and children and thresholds for different forms of risk management and intervention. However, the matrix is yet to be rigorously evaluated (Stanley & Humphreys, 2014)

The PATRICIA Project (**PAT**hways and **R**esearch **I**n **C**ollaborative **I**nter-**A**gency practice) sought to generate new knowledge to inform improved collaboration in the child protection and family violence sectors through action research (Connolly, Healy, & Humphreys, 2017). The Australian project identified three domains that are critical to facilitating good collaborative practice: integrated service focus, democratizing practices, and partnership supportive collaboration. The integrated service focus emphasises the importance of specialist expertise, including collaboration between child protection and specialist family violence services at a minimum. Collaboration may additionally include family support, mental health, drug and alcohol, disability, Indigenous, and CALD services. An example of a question to guide practice is: in what ways are we sharing data and data analysis to inform service improvement? Democratising practices highlight the importance of valuing all voices in decision-making and development of the partnership. An example of a question to guide practice is: do we have a shared and equal investment in outcomes for women and children? Finally, partnership supportive collaborations refer to the need to create an environment that legitimises the processes used across systems, including clear accountability expectations. An example question is: are the expectations of collaboration clearly authorized-e.g. in PDs?

Alternative processes for responding to family violence

Family Group Conferences (FGC) is an alternative process for responding to family violence that originated in New Zealand in response to the over-representation of Maori children in the child protection system. The strengths-based approach actively involves the family, alongside the professionals, in decision-making about children in the family. Operating from a restorative justice philosophy, the approach also includes the perpetrator in the sessions to encourage them to understand and take responsibility for their actions (Rogers & Parkinson, 2017). Studies comparing the outcomes of FGCs to traditional child protection services have found mixed results (Frost, Abram, & Burgess, 2014). However, quantitative and qualitative data does indicate that FGCs can support the recovery process, resulting in fewer children entering state care/more children remaining in the care of their families; improved contact arrangements between children in care and their families; families developing safety plans for children; children and families feeling more engaged in the process; and more fathers being engaged than in traditional child protections processes (Rogers & Parkinson, 2017). Research is needed to determine the intermediate and longer term effects of FGCs (Fox, 2008).

Additional services to support children and young people exposed to domestic violence

Receiving support from the non-abusive parent can improve the outcomes for children exposed to family violence (Smith et al., 2015). However, the mother-child relationship can be strained through the experience of family violence and family abuse recovery programs do not appear to prioritise strengthening this relationship in their programs. Domestic Abuse Recovering Together (DART) is a 10-week program that focusses specifically on strengthening the mother-child relationship after the abuse has ended and supporting other aspects of recovery. Mothers who participated in DART had significantly improved self-esteem which was maintained six months post

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intervention. Children who participated in the program had a significantly greater reduction in their 'total difficulties' and 'conduct' problems than the comparison group (Smith et al., 2015).

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Service system responses to children and young people in the statutory child protection system who have experienced or witnessed family violence

Appendix 1.1: Search strategy

Limits

2000 -2017; in English

Database	Search terms	Yield
Academic Search Complete	"child protection" AND "domestic violence" OR "family violence" AND collaboration OR "systems working" OR "integrated working" OR "partnership working" OR "service responses"	28
Academic OneFile	"child protection" AND "domestic violence" OR "family violence" AND collaboration OR "systems working" OR "integrated working" OR "partnership working" OR "service responses"	14

Additionally, reference lists of included studies were scanned for further articles of relevance and grey literature was obtained from experts in the field.

Appendix 2

Additional information supplied by from the Queensland Department of Child Safety, Youth and Women (2019).

Definition: What is domestic and family violence?

Queensland's Domestic and Family Violence Prevention Strategy 2016-2026 (Queensland Government, 2016a, p. 1), identifies domestic and family violence as "any behaviour that is physically, sexually, emotionally, psychologically, economically, spiritually and culturally abusive, threatening, coercive or aimed at controlling or dominating another person through fear".

Domestic and family violence occurs when one person in an intimate personal, family or informal carer relationship uses violence or abuse to maintain power and control over the other person. Broadly, under Queensland law, it includes behaviour that is physically, sexually, emotionally, psychologically or economically abusive, threatening, coercive or aimed at controlling or dominating another person through fear. The violence or abuse can take many forms ranging from physical, emotional and sexual assault through to financial control, isolation from family and friends, threats of self-harm or harm to pets or loved ones, constant monitoring of whereabouts or stalking.

Under the Domestic and Family Violence Protection Act 2012 (Qld), intimate personal relationships include married and defacto spouses; parents of a child; people who are, or were engaged; and people in couple relationships, including same-sex couples. Family relationships exist between two people who are related by either blood or marriage, including extended or kinship relationships where a person is regarded as a relative. Informal care relationships exist where one person is or was dependent on another person for help with essential daily tasks, such as dressing or grooming, meal preparation, grocery shopping or arranging medical care, where care is provided other than on a commercial basis.

For more detailed information refer to the Department of Child Safety, Youth and Women's Domestic and Family Violence Prevention Strategy 2016-2016.

https://www.csyw.qld.gov.au/campaign/end-domestic-family-violence/dfvp-strategy

In addition, below are the Action Plans developed to support the implementation of the DFVP Strategy.

First Action Plan 2015 – 2016

https://www.csyw.qld.gov.au/resources/campaign/end-violence/dfv-first-action-plan.pdf

Second Action Plan 2016/17 to 2018/19

https://www.csyw.qld.gov.au/resources/campaign/end-violence/dfv-second-action-plan.pdf

Third Action Plan 2019/20 to 2021/22

https://www.csyw.qld.gov.au/resources/campaign/end-violence/third-action-plan.pdf

Not Now, Not Ever: Putting an end to domestic and family violence in Queensland.

On 28 February 2015, the Premier received the report of the Special Taskforce on Domestic and Family Violence in Queensland, Not Now, Not Ever: Putting an end to domestic and family violence in Queensland.
The report made 140 recommendations based on the insights gathered from 5 months of engagement with communities and individuals. The recommendations for change had a focus on providing practical solutions under three themes: changing culture and attitudes, implementing an integrated service response, and improving the law and justice system. The recommendations set the vision and direction for Queensland's strategy to end domestic and family violence and ensure those affected have access to safety and support.

Further information and recommendations from the report can be found via the following link.
https://www.csyw.qld.gov.au/resources/campaign/end-violence/about/dfv-report-vol-one.pdf

The Department of Child Safety, Youth and Women has led work across government and the community to design, implement and test holistic and integrated approaches to improving the safety of domestic and family violence victims and their children while holding perpetrators to account for their violence.

This approach formed part of the Queensland Government's response to recommendations 9, 74, 75, 76, 77, 78, 79, 80, 82 and 83 in the Not Now, Not Ever report. An integrated service response is an innovative approach which ensures coordination of services and supports across government, non-government services and other community organisations.

An integrated service response trial has been conducted in three locations:
- Logan/Beenleigh (urban location)
- Mount Isa/Gulf (regional city location)
- Cherbourg (discrete Indigenous community location).

The integrated service response trial focused on how service systems can work together in a timely, structured, collaborative way to ensure people affected by domestic and family violence receive quality and consistent support. Each location engaged in a co-design process. For example, the Cherbourg response was co-designed to provide a culturally specific integrated response to domestic and family violence that is tailored to the needs of that community.

High risk teams are a core component of Queensland's integrated service response approach. These teams consist of officers from all agencies with a role in keeping victims safe and holding perpetrators to account — including police, health, corrections, housing and domestic violence services — collaborating to provide integrated, culturally appropriate safety responses to victims and their children who are at high risk of serious harm or lethality.
High risk teams using Queensland's first common risk assessment and safety management framework are currently operating in:
- Logan/Beenleigh
- Mount Isa/Gulf
- Cherbourg
- Moreton Bay (Brisbane)
- Ipswich
- Cairns
- Mackay
- Moreton Bay (Caboolture)

The roll out of integrated service responses to domestic and family violence in Queensland has a staged approach that started with the Logan/Beenleigh site in January 2017, followed by Mount Isa and Cherbourg in August 2017. The high-risk teams in Moreton Bay (Brisbane), Ipswich, Cairns, Mackay and Moreton Bay (Caboolture) were progressively rolled-out between February 2018 and April 2019. This brings the total number of high-risk teams using this common framework in Queensland to eight.


Safe and Together Model
The Safe and Together model (Mandel, 2017), uses a perpetrator pattern-based definition of domestic violence, which strengthens the ability of the practitioner to understand how the perpetrator is creating harm or the risk of

harm to children. This is important as a perpetrator can be adept at 'image-making' creating a perception of the victim as the problem, crazy or difficult, particularly if the victim has used 'violent resistance or reactionary use of violence (Queensland Government, 2017c).

In implementing this model, practitioners hold fathers who are perpetrators to the same standard of parenting expectations as mothers. Use of the model provides more detailed assessment of the perpetrator's pattern of behaviour. This information is central to understanding the victim's decision-making.
Under this model there are three key principles:

The critical components of the model are outlined below. These components ensure the perpetrator remains visible and removes the potential for 'mother blaming' through the identification of domestic and family violence as a parenting choice by the perpetrator.
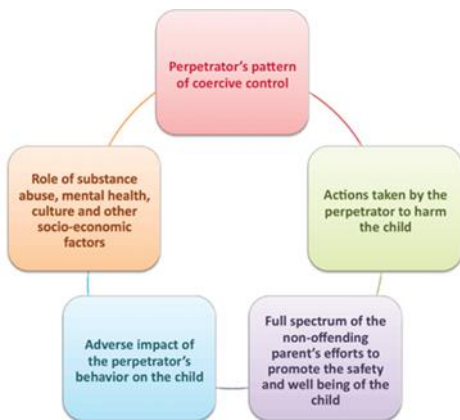
UNIFY

The Department of Child Safety, Youth and Women has established a four-year program to implement a contemporary case and client management system to enable to best outcomes for children, young people and their families. This means the Unify Program will progressively implement a replacement for the Integrated Client Management System (ICMS). At the heart of this multi-year program is the vision to implement a contemporary case and client management system that will enable the best outcomes for vulnerable children, young people and their families.

The program will be:

- Client-centric: supporting targeted, needs-based responses to children, young people, parents, families, carers and communities while delivering earlier and more effective interventions.

- Data-driven: improving how we manage data to enable the effective monitoring of outcomes and ensuring that future investment is directed to what works
- Integration-enabling: designed around collaboration and information sharing, enabling connected and integrated responses to clients across government agencies and non-government partners.

The program has a broader focus, including:

- better supporting our staff
- continuing our service reforms
- enabling more streamlined processes
- enabling our engagement with young people, families, carers and services
- improving information sharing and collaboration across Queensland Government and with the social and justice sectors.

The program will build on the work already well underway with digital initiatives such as iDocs, Our Child, Carer Connect, CSXpress, kicbox and CourtShare.

Our Child

Our Child is a secure real-time multi-agency information sharing platform to support the Queensland Police Service and the department to rapidly locate children in care who have been reported as missing. Our Child currently allows the Queensland Police Service and relevant departmental staff to access information from ICMS, the Department of Education's OneSchool system, the Office of the Public Guardian's Jigsaw system and Queensland Health's information systems when a child in care has been reported as missing - all through a user-friendly portal.

It is anticipated Our Child will continue to grow with more government agencies coming on board in the future.

Carer Connect

Carer Connect is a web and mobile friendly app that has been developed to provide carers with improved and secure access to information and support, when and where they need it. The app is an outcome of the extensive consultation with foster and kinship carers through the Partners in Care engagements across Queensland in 2017. Carers can view relevant information and documentation to gain an understanding of how the needs of the children in their care can best be supported.

Information available may include:
- Placement agreement and Authority to Care
- medical information, e.g. serious health condition alert, health passport and immunisations
- Child Safety contact information, including after-hours phone number
- type of child protection order and expiry date
- cultural information
- current education information.

In addition to viewing child and carer entity information, carers can:
- upload pictures of their home and family that can be shown to children when they are transitioning to a new placement

- view noticeboard articles that announce everything from training and social events to legislation changes.

https://www.qld.gov.au/community/caring-child/foster-kinship-care/information-for-carers/carer-connect)

Kickbox

kicbox is a platform for recording a digital life story for children and young people in out-of-home care. Once a child (of any age) has been in care for 30+ days they will be setup with a kicbox account. This allows foster and kinship carers and Child Safety staff (that are working with the child) to start contributing to the account and building the child's digital life story. The Department of Child Safety, Youth and Women designed the app in collaboration with young people living in out-of-home care and their care teams. From mid-March 2018, kicbox will be available in all regions across Queensland. When that happens, your Child Safety team will create a kicbox account for you.

https://www.qld.gov.au/youth/family-social-support/young-people-in-care/kicbox)

Structured Decision Making (SDM)

Structured Decision-Making assists practitioners to work with families and to focus resources on those families, in an effort to reduce the incidence of subsequent harm and neglect. The SDM assessments and associated service responses are used to identify critical decision-making points and improve the structure and consistency of the decisions made and the services provided. For further and more detailed information refer to the link below.

https://www.csyw.qld.gov.au/childsafety/child-safety-practice-manual/structured-decision-making/what-structured-decision-making

Appendix 3: Participant information sheet

PROJECT TITLE: Child protection interventions- Statutory responses for children experiencing family violence
APPLICATION NUMBER: (2017–309E)
PRINCIPAL INVESTIGATORS: Prof. Daryl Higgins and Prof. Morag McArthur (ACU)

Dear Participant,

You are invited to participate in the research project described below.

What is the project about?
This project has been commissioned by the Australian government Department of Social Services as part of *the National Plan to Reduce Violence Against women and their Children 2010-2022.* The study aims to provide a clearer picture of the nature of families that seek and either succeed or fail to engage with the family violence system in order to facilitate effective collaboration and information sharing between the family law, family violence and child protection system. The research project investigates service system responses to child protection cases that involve family violence.

We are conducting interviews with both Queensland Department of Communities, Child Safety and Disability Services case managers and agency practitioners of family violence and other family support services. You have been invited to participate in an interview in reference to a particular client or family that has currently open child protection case. The interview will involve discussion around the interventions/services available for cases involving family violence, the risks and impact of DV on children, decision making about the risks involved for the child and/or adult victims/survivors' decisions and process for making referrals and the barriers and enablers to working across systems.

An email sent to you by from the Queensland Department of Communities, Child Safety and Disability Services would have informed you about the project to gauge your interest in the project. The email would have also identified a client by name or departmental Integrated Client Management System (ICMS) ID and given you an **ACU study ID** for this client or family. **Please only refer to the client or family by the study ID.**

Who is undertaking the project?
This project is being led by the Institute of Child Protection Studies at the Australian Catholic University under principal investigators Professor Daryl Higgins Professor Morag McArthur. Co- investigator Dr Debbie Scott (Monash University) and project manager Alex Cahill are also working on the project. The research team is made up of experienced academics that all have working with children checks.

Are there any risks associated with participating in this project?
The risks pertain to confidentiality and privacy of families. Please refer to the case discussed in the interview as the study ID provided to you. The department of Department of Communities, Child Safety and Disability Services will not be informed whether or not you participated in the study.

What will I be asked to do?
You will be asked to participate in a telephone interview with a researcher which will be digitally recorded.

How much time will the project take?
The telephone interview will go for approximately half an hour to 1 hour and will be recorded.

What are the benefits of the research project?
This research will offer workers the opportunity to voice their views and experiences on service system responses to child protection cases that involve family violence.

Can I withdraw from the study?
Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time during the interview without adverse consequences or giving a reason. If you withdraw

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during the interview the data recorded will be destroyed. After the interview is complete, the recording will be de-identified and transcribed. You will be unable to withdraw your data after this point as it will not be identifiable.

Will anyone else know the results of the project?
The data collected in this research project will be used to write a final report about the research findings and the contributions you provide may be used to develop some articles which we will publish for others to read in academic journals or conference presentations. We will ensure that any information that might identify particular children, families, services, workers or other individuals will be removed from any articles and will not be accessible to anyone outside of the research team. Any information provided is confidential, unless you tell the researcher something that concerns them about your safety. Data from the interviews will be securely stored on computer files at the Australian Catholic University under the responsibility of the Chief Investigators (listed).

Will I be able to find out the results of the project?
In June 2018 a report will be provided to the Department of Social Services and the Queensland Department of Communities, Child Safety and Disability Services which we expect will be made publicly available.

Who do I contact if I have questions about the project?
If you have any questions about the project, please contact:
Professor Daryl Higgins (see details below), Australian Catholic University or contact the project manager **Ms. Alex Cahill 0431 895 197 or via email at alex.cahill@acu.edu.au**

What if I have a complaint or any concerns?
The study has been reviewed by the Human Research Ethics Committee at Australian Catholic University (review number 2017–**309E**). If you have any complaints or concerns about the conduct of the project, you may write to the Manager of the Human Research Ethics Committee care of the Office of the Deputy Vice Chancellor (Research).

Manager, Ethics
c/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
North Sydney Campus
PO Box 968
NORTH SYDNEY, NSW 2059
Ph.: 02 9739 2519
Fax: 02 9739 2870
Email: resethics.manager@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?
If you are interested in participating in the study, please reply the mail you received this attachment in or contact Alex Cahill on the details mentioned above.

Yours sincerely,
Professor Daryl Higgins
ICPS Director
Australian Catholic University
Institute of Child Protection Studies
Melbourne Campus, Level 5, 215 Spring St, Melbourne, Victoria
T +61 (0)3 9953 3607 E daryl.higgins@acu.edu.au

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Appendix 4: Participant consent form

TITLE OF PROJECT: Child protection interventions- Statutory responses for children experiencing family violence

CHIEF INVESTIGATORS: Prof. Daryl Higgins and Prof. Morag McArthur (ACU)
CO-INVESTIGATORS: Dr Debbie Scott (Monash University)

I .... *(the participant)* have read *and* understood the information provided in the Letter to Participants. Any questions I have asked, have been answered to my satisfaction. I agree to participate in the 30 minutes, recorded telephone interview*,* realising that I can withdraw my consent at any time during the interview (without adverse consequences). I agree that research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way. In the interview we will discuss these issues in regard to client (study ID only) _____. I agree **NOT** reveal any names or identifying features of the client(s).

NAME OF PARTICIPANT:

SIGNATURE:

DATE:

NAME OF THE RESEARCHER: Ms. Alex Cahill

Appendix 5: Interview guides

Interviews were semi-structured and followed the issues and topics listed below.

Telephone Interviews with Departmental CSOs

Interview questions associated with the specific case for the case worker were carried out to understand:

- Is this case typical in terms of circumstances/ complexity or what is different about it?

- What was the nature of the interventions that were carried out?

- What decisions were made about the risks to the child?

- How did you decide and what processes do you have for making referrals?

- What are the barriers and enablers to working across systems for practitioners?

- Follow-up on referral bookings and attendance – does this happen, by whom, what are the consequences of not attending?

- How does the complexity of the case affect the use referral and use of services?

- What services would remain or be available to parents and the child once the child is removed?

Telephone Interviews with practitioners at non-government agencies (including DFV services, or other out-sourced family support services)

Interviews were about a specific case and focused on the following key issues:

- Is this case typical of in terms of circumstances/ complexity or what is different about it?

- What is the nature of the service/interventions (e.g., if they are specialised family violence services or general family support; who is the target of the service – the child, the mother, etc.)?

- Do these services lead to differential outcomes such as time the case is open, or the number of re-referrals to child protection within a given period?

- What are the barriers and enablers to working across systems for practitioners?

- What is the level of understanding of the risks and impact of family violence on children?

- Has the Department followed-up on attendance to your services?

- How does the complexity of the case affect the referral and use of services?

- Would your service be available to the parents or the child once the child is removed?