# Child Death Review Board

Queensland Family & Child Commission

## Reviewing the child protection system's response to violence within families

*Findings from an analysis of child death reviews involving domestic and family violence*

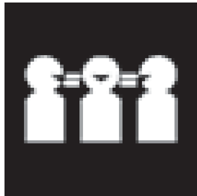
Queensland Government

## About this report

The Child Death Review Board (CDRB) is an independent board established on 1 July 2020 to carry out reviews of the child protection system following the deaths of children connected to it. These reviews aim to identify opportunities for improvement in systems, legislation, policies, and practices and to identify mechanisms to help prevent deaths that may be avoidable.

This report has been prepared under section 29D of the *Family and Child Commission Act 2014* which enables the CDRB to carry out, or engage persons to carry out, research relevant to reviews of the child protection system following the deaths of children connected to it.

## Accessibility



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## Acknowledgements

The Queensland Child Death Review Board (CDRB) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies on which we walk, live and work.

We recognise Aboriginal and Torres Strait Islander peoples as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to their Elders past, present and emerging.

The CDRB recognises the rich and resilient cultures that continue to sustain and strengthen Aboriginal and Torres Strait Islander peoples. We respect the right to self-determination and the critical importance of continuing connection to kin, Country and culture in the lives of Aboriginal and Torres Strait Islander peoples.

The CDRB acknowledges the important work of the child protection system in protecting children and helping their families and communities to care for them. The CDRB remains committed to working with agencies and stakeholders to make the changes needed to promote the safety and wellbeing of children and help prevent future deaths.

The CDRB would like to thank Dr Samara McPhedran for reviewing contemporary research relating to children's and families' experiences of domestic and family violence and effective system responses to inform this report. Dr McPhedran is a Policy and Research Consultant. She has previously held a range of academic and public sector roles and is also an Honorary Associate Professor with the TC Beirne School of Law, University of Queensland. She has worked extensively at the intersection between social policy and law, and has particular expertise in violence and its prevention, mental health, and suicide.

### Warning

*This report contains information about the deaths of children in Queensland. This report may cause distress for some people. If you need help or support, please contact any of these services:*

***Lifeline**:* *13 11 14*

***Beyond Blue**:* *1300 22 4636*

***Kids Helpline**:* *1800 55 1800*
*(for 5–25-year-olds)*

*Aboriginal and Torres Strait Islander peoples should be aware that this report contains information about deceased children and systemic issues facing Aboriginal and Torres Strait Islander peoples.*

## Message from the Chair

The Child Death Review Board (CDRB) has the important responsibility of reviewing information about system responses following the deaths of children known to the child protection system. This work provides important insights into the way our child protection system responds to children and families and the improvements needed to help keep children safe.

Domestic and family violence is present in most cases reviewed by the CDRB. While domestic and family violence is often not directly associated with the deaths of children reviewed by the CDRB, reviewing system responses to them and their families offers opportunities to explore improvements needed.

The CDRB undertook a review of system responses to domestic and family violence using the collective findings and reflections identified through Queensland's two-tiered child death review process—reviews completed by service delivery agencies and the CDRB. This review was based on the experiences of 43 children and young people who came before the CDRB. All were known to the child protection system and had experienced domestic and family violence within their family or household.

On behalf of the CDRB, I would like to acknowledge this tragic loss of life and the grief experienced by their families, communities and the professionals who worked with them. While the CDRB identified system oversights and opportunities for improvement, it was apparent that agencies and services acted with good intent. What our findings suggest is that there remain opportunities to strengthen practices and service delivery to children which recognise the harm caused by domestic and family violence.

In Queensland, there has been significant investment and reform to strengthen our awareness and response to domestic and family violence. This work is ongoing, and the CDRB recognises that more time is needed for changes to be fully implemented and impacts for children and families to be realised. It is critical that the experiences and needs of children and young people continue to be at the forefront of this work. As highlighted through this review, there are times that their voices and needs are lost when the system heavily focuses on responding to their parents. The CDRB remains committed to sharing findings and working with stakeholders for this purpose.

Luke Twyford
Chairperson
Child Death Review Board

## Table of contents

**Acknowledgements** ..... 3

**Message from the Chair** ..... 4

**Executive summary** ..... 6

Recognise and assess ..... 6

Respond ..... 7

Build capacity ..... 7

**1. Introduction** ..... 9

1.1. Child Death Review Board ..... 10

1.2. Project scope and methodology ..... 10

**2. The system in place** ..... 11

**3. Case analysis findings** ..... 12

3.1. Recurring system issues ..... 12

**4. System improvements** ..... 27

**5. CDRB focus areas** ..... 28

Recognise and assess ..... 28

Respond ..... 28

Build capacity ..... 29

**Appendices** ..... 30

Appendix A—Methodology ..... 30

Appendix B—Child Safety lethality indicators and risk factors ..... 32

**Attachments** ..... 35

Attachment A—Literature Review ..... 35

## List of tables and figures

Figure 1: Prevalence of multiple factors within sample cases ..... 14

Table 1: Commonly reported parental factors ..... 13
Table 2: Type of violence reported by agencies ..... 15
Table 3: Number of lethality indicators identified ..... 18
Table 4: Number of high-risk factors identified ..... 19
Table 5: Referrals to secondary services for domestic and family violence support or intervention ..... 22
Table 6: Themes from agency review report recommendations ..... 27
Table 7: Number of reports received from review agencies ..... 30

## Executive summary

It is widely established that children's exposure to domestic and family violence can have significant and damaging short- and long-term impacts on their development, health, behaviour, and psychological and emotional wellbeing. The co-occurrence or co-reporting of domestic and family violence and child harm often brings families into contact with the child protection system (the system)[1] resulting in the reported prevalence of violence among this population being higher.

Since it was established, the CDRB has observed a high prevalence of child death cases[2] where domestic and family violence was present and was a factor in system responses to the child and their family. In most cases, violence was not directly related to, or did not immediately precede, the child's death. However, reviewing service delivery and responses to these children and families presents opportunities to identify recurring issues and discuss any changes required for improving systems and practices.

The CDRB reviewed a sample of agency and CDRB child death reports to analyse system responses to children and families in the year prior to the child's death, and identify opportunities for improvements. This report outlines the findings from this review, supplemented by a review of Australian and international literature outlining what is known about service engagement (including perpetrator programs), comorbidity of risk factors and coordinated system responses to children and families who experience domestic and family violence. While based on a small sample of child deaths, findings highlight areas where system responses could be strengthened.

These are grouped under the following three sections:

### RECOGNISE AND ASSESS

Key findings:

- All forms of domestic and family violence and lethality indicators are not always recognised or understood by agencies and therefore the associated risks to children may not be obvious.
- Children's voices and views are not always appropriately sought or heard when the system responds to parents—minimising the harm they may have experienced.
- Cross-agency collaboration and information sharing is important for maintaining 'visibility' of perpetrator behaviours, understanding and minimising risks their behaviours pose to children and addressing comorbid risk factors.

The case analysis highlighted that children experienced multiple types of domestic and family violence (with physical and emotional violence and coercive control often being co-reported). However, some types of violence were missed by agencies—this was reflected in vague statements about domestic and family violence or a focus on evidence of physical violence and previously reported incidents. There was also evidence of harm (or risks) to children being missed or minimised, particularly where children were not interviewed appropriately, decisions about their safety were made based on incomplete information or risk assessments did not consider all types of harm caused by domestic and family violence.

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[1] The child protection system (the system) refers to the services provided by relevant agencies or entities to children and young people in need of protection or at risk of harm (such as Child Safety, Youth Justice, police, schools and hospital and health services). This also includes preventative and support services to strengthen and support families and prevent harm to children and young people.

[2] The CDRB reviews the child protection system following deaths of children who were known to the system in the 12 months prior to their death. This includes children who were reported to Child Safety due to alleged harm or alleged risk of harm, were subject to action by Child Safety under the *Child Protection Act 1999* (such as an Investigation and Assessment or an Intervention with parental agreement), in the custody or guardianship of Child Safety or unborn children where Child Safety was notified of concerns and reasonably suspected that the child might be in need of protection following birth.

## RESPOND

Key findings:

- There are missed opportunities to hold offending parents accountable and address the risk their behaviours pose to children when they are not included in investigations or interventions.
- Domestic and family violence supports and services play a key role in supporting parents and children, however uptake was low. There are multiple individual and organisational barriers which can inhibit service uptake and engagement.
- Culturally- and trauma-informed pathways and service provision are needed to enhance support for First Nations families.
- 'Fatherhood' can be a significant motivator to encourage fathers to accept accountability and facilitate behaviour change, however fathering practices are not well embedded in men's behaviour change programs and there is limited formal evidence about the effectiveness of programs in improving outcomes for children.
- There are gaps in system responses to children and young people which recognise and respond to their violent or aggressive behaviours in the context of intergenerational experiences of domestic and family violence and trauma.

As highlighted by the sample cases, domestic and family violence rarely occurs in isolation of other factors—particularly parental substance use and poor mental health. Promising practices include strengthening intersections between violence, substance use treatment and mental health, with a focus on children and keeping perpetrators 'visible' across the system.

Among the sample cases, system referrals to domestic and family violence services or support appeared to focus on parents, with the assumption that this would improve circumstances and allow them to better care for their children. Among these, there was low uptake of referred services—particularly by the offending parent—with several barriers identified for this. For some First Nations families, these barriers included referrals to mainstream services without discussions about culturally appropriate and informed options.

## BUILD CAPACITY

Key findings:

- Cumulative harm (caused by children's ongoing experiences of domestic and family violence) can be difficult to identify when staff have limited capacity to undertake thorough child protection history reviews.
- Limited knowledge or training can lead to responses that do not recognise complex factors that surround domestic and family violence and result in suboptimal responses to children and parents. Training (particularly in the Safe and Together model) is seen to be integral to the solution for supporting frontline staff to identify and respond to violence. However, workforce capacity and turnover presents challenges for delivering training and retaining collective workplace knowledge.
- Individually, agencies have identified actions or recommendations for strengthening domestic and family violence responses, particularly in relation to delivering training and reviewing tools and practices.

A recurring issue reported by review agencies, and reflected in their recommendations, related to the capability and capacity of staff to respond appropriately to domestic and family violence. The case analysis highlighted the need for strong understanding of violence when assessing the risks it poses to children and to respond effectively in an environment where workers are experiencing high workloads. For example, there were instances of agencies not including offending parents in assessments or responses, language that placed sole responsibility on non-offending

parents and risk assessments that did not consider cumulative harm caused violence or seek to understand the impact of violence from children’s perspectives. Cross-agency protocols and training are seen to be promising practices for improving collaboration and knowledge of the interface between domestic and family violence and child protection. While the rollout of promising programs and training continues, the system is faced with the challenge of retaining specialist knowledge in light of workforce turnover.

# 1. Introduction

The impact of domestic and family violence on children is a significant social issue which has become the focus of community concern[3] and strengthened a focus on parental and system responsibility for protecting children. Experiencing violence can have a wide range of detrimental impacts on children's development, mental and physical health, behaviour and wellbeing.[4]

***Definition***

*Throughout this report, the child protection system (the system) is used to refer to services provided by relevant agencies or entities to children and young people in need of protection or at risk of harm (such as Child Safety, Youth Justice, police, schools and hospital and health services).*

*This also includes preventative and support services to strengthen and support families and prevent harm to children and young people.*

It is difficult to accurately estimate the prevalence of domestic and family violence among families. Evidence drawn from parents' and children's self-reported experiences of violence suggest that approximately one-third of parents in the general community experience violence.[5] The Australian Bureau of Statistics Personal Safety Survey (2016) also suggests a high proportion of Australian children experience violence in their home:

- of the women who reported experiencing violence while living with their current partner, 44.1 percent had children in their care
- of the men who reported experiencing violence while living with their current partner, 32.8 percent had children in their care.[6]

The co-occurrence or co-reporting of domestic and family violence and child harm often brings families into contact with the system resulting in this estimate being reportedly higher among this population. In the year ending 30 June 2021, violence was recorded in half of all households subject to a substantiated investigation and assessment (where it was assessed a child had experienced harm) by the Department of Children, Youth Justice and Multicultural Affairs (Child Safety).[7]

Article 19 of the United Nations Convention on the Rights of the Child notes the responsibility of governments to protect children from all forms of violence, abuse, neglect or exploitation while in the care of parents, guardians or carers.[8] This includes domestic and family violence.

The system needs ways to minimise the risks to children posed by domestic and family violence while working with their families to address their behaviours. To understand current system responses and identify any improvements

[3] In a recent survey of community perceptions, domestic and family violence was the most commonly cited issue raised by respondents (n=2,335) when asked to consider the biggest issue affecting the safety, wellbeing and rights of children in Queensland. Queensland Family and Child Commission 2021, *QFCC Community perceptions survey 2021: Research report,* https://www.qfcc.qld.gov.au/sites/default/files/2021-12/2021CommunitySurveyReport%20%281%29.PDF

[4] Australian Institute of Health and Welfare 2022, *Australia's children—Children exposed to family violence,* https://www.aihw.gov.au/reports/children-youth/australias-children/contents/justice-and-safety/children-exposed-to-family-violence

[5] Australia's National Research Organisation for Women's Safety 2016, *Domestic and family violence and parenting: Mixed methods insights into impact and support needs: State of knowledge paper*, https://apo.org.au/sites/default/files/resource-files/2016-01/apo-nid60845.pdf

[6] Australian Bureau of Statistics 2017, *Personal Safety Survey Australia (2016)*, https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/latest-release#experience-of-violence

[7] Department of Children, Youth Justice and Multicultural Affairs 2021, *Our performance: Family and household risk factors. Table FP.1: Prevalence of parent risk factors in substantiated households, Queensland. Accessed 07 March 2022.* Where the household experienced two or more instances of domestic violence during the 12 months prior.

[8] United Nations Convention on the Rights of the Child, United Nations Convention on the Rights of the Children (unicef.org.au)

needed, the Child Death Review Board (CDRB) undertook a review of child death cases where violence was a factor in system responses to the child and their family. This review focused on system responses to children and their families in the 12 months prior to the child's death, rather than on the death incident.

### 1.1. CHILD DEATH REVIEW BOARD

The CDRB was established under the *Family and Child Commission Act 2014* (Qld) to carry out system reviews following the deaths of children connected to the child protection system.

To do this, the CDRB identifies and explores patterns, trends and risk factors relating to system responses to children and young people. Its mandate includes undertaking research to generate system-wide findings and recommendations for system improvements to reduce and prevent child deaths.

Since it was established, the CDRB has observed a high prevalence of child death cases[9] where domestic and family violence was present and was a factor in system responses to that child and their family. The CDRB has discussed several recurring issues which impact on the quality and timeliness of service provision to children and families experiencing violence. The CDRB commenced this review to examine recurring issues and identify opportunities for improvements in how the system responds to children and families experiencing violence.

### 1.2. PROJECT SCOPE AND METHODOLOGY

The purpose of this project was to:

- analyse the characteristics of, and system responses to, domestic and family violence among families where a child's death was reviewed by the CDRB
- identify evidence to inform the CDRB's recommendations for improvements to the way in which the child protection system responds to domestic and family violence within Queensland's most vulnerable families.

Since it was established, the CDRB observed a high prevalence of domestic and family violence among the cases it reviewed. This review focused on a sample of 43 cases where available records indicated that the violence was a factor in system responses to the child and their family within the 12 months prior to the child's death.

*The CDRB reviews the deaths of all children known to the Queensland child protection system in the 12 months prior to their death.*

*While there was a high prevalence of domestic and family violence within this cohort, in most cases, this was not directly related to, or did not immediately precede, the child's death. Accordingly, this review did not examine correlations between domestic and family violence and cause of death.*

Almost three-quarters of these cases related to the deaths of very young children (aged up to 4 years).

Approximately 44 percent related to the death of Aboriginal and/or Torres Strait Islander children. This should not be misinterpreted as an indicator that domestic and family violence is predominantly an issue among Aboriginal and Torres Strait Islander families or communities. Instead, it must be considered in the broader context of the over-representation of the Aboriginal and Torres Strait Islander children known to the child protection system and among child death statistics.

[9] The CDRB reviews deaths of children who were known to the child protection system in the 12 months prior to their death. This includes children who were reported to Child Safety due to alleged harm or alleged risk of harm, were subject to action by Child Safety under the *Child Protection Act 1999* (such as an Investigation and Assessment or an Intervention with parental agreement), in the custody or guardianship of Child Safety or unborn children where Child Safety was notified of concerns and reasonably suspected that the child might be in need of protection following birth.

The project involved two key phases.

1. Case analysis—Reviewed agency and CDRB review materials for the 43 cases to capture information relating to descriptions of domestic and family violence and oversights or issues relating to agency and system responses to the violence.
2. Literature review—Commissioned a literature review relating to topics identified through the case analysis and by the CDRB (**Attachment A** contains the findings from the literature review).

*Information used to inform the case analysis was primarily derived from Child Safety records (including Systems and Practice Review reports and source documents) given that Child Safety reviews every death of a child known to the child protection system and records were available for the full period.*[10]

*Findings of this project may often relate to Child Safety given that more information about system responses was available. However, all agencies and services within the child protection system have a role to play in the identification and response to domestic and family violence. Opportunities for improvement should focus on whole-of-system responses.*

The proportion of CDRB cases where domestic and family violence was present may be higher than the proportion identified through this project. It can be difficult to accurately record the prevalence of violence, as incidents frequently occur behind closed doors and can be concealed or denied by offending parents and sometimes by non-offending parents and their children. Data sources only captured incidents that were disclosed by individuals and recorded by review agencies (such as Police or Child Safety). It was not feasible or within the scope of the project to request additional information or documents to confirm allegations of violence or request information held by non-review agencies.

Further details about the project methodology and limitations are presented in **Appendix A**.

## 2. The system in place

Over recent years, Queensland has undergone significant reform in terms of how it responds to domestic and family violence. In 2015, the *Not now, not ever* report made 140 recommendations to set a vision and direction for Queensland's strategy to end domestic and family violence and ensure those affected have access to safety and support. The subsequent *Domestic and Family Violence Prevention Strategy 2016–2026* outlines the building blocks and principles for eliminating domestic and family violence, supported by several plans outlining specific actions to be undertaken by government in partnership with the non-government sector, business and Queensland community.[11] These give specific consideration to addressing other factors that contribute to violence, such as poverty, unemployment, drug and alcohol use and poor mental health.

One of the significant changes stemming from the *Not now, not ever* report was the establishment of the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB). The DFVDRAB is responsible for the systemic review of domestic and family violence deaths in Queensland and making recommendations to prevent or reduce the likelihood of these deaths. Over the past five years, the DFVDRAB has made wide-reaching recommendations to systems, policies and practices to reduce violence and address contributing factors. This has included

[10] Other review agencies were required to provide child death review reports to the CDRB from 1 January 2021.

[11] Queensland government, *Domestic and Family Violence Prevention Strategy 2016–2026*, https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/008db60d-06e9-4702-bb87-48be367edf93/dfv-prevention-strategy.pdf?ETag=ef56a614ca32eedadca2acffc3f37578

recommendations specific to agencies within the child protection system and focused on identifying risks to children.

The Queensland Government also announced the establishment of a Women's Safety and Justice Taskforce to conduct a wide-ranging review into the experiences of women across Queensland's criminal justice system (announced in March 2021) and a Commission of Inquiry into policing responses to domestic and family violence (announced in May 2022). The findings and recommendations of the DFVDRAB and the Women's Safety and Justice Taskforce and the Commission of Inquiry will significantly shape the ongoing approach to responding to violence within Queensland.

Concurrently, practices and programs directly intended to promote the safety and wellbeing of children have evolved in line with domestic and family violence reforms—notably, the rollout of the Safe and Together model within Child Safety since 2015. This model entails three core principles:

- keeping the child safe and together with the non-offending parent
- partnering with the non-offending parent as the default position
- intervening with the perpetrator to reduce risk and harm to the child.[12]

# 3. Case analysis findings

## 3.1. RECURRING SYSTEM ISSUES

Children experience a range of consequences of domestic and family violence in their homes, including being subjected to deliberate or actual violence; witnessing or overhearing violence; intervening to try and protect a parent; experiencing the aftermath of violence, such as dealing with a distressed parent, police and emergency services attending the home; living in a household dominated by tension or fear and being asked to keep events a secret.

Importantly, a child need not be present, see, or hear domestic and family violence to be impacted or harmed by its occurrence.

> *Children are not 'exposed' to domestic violence, in that it's not just something they witness and move on. They experience direct and lasting harm. Domestic violence can impact on every aspect of a child's life—from how they experience each day, to their self-esteem and their own relationships. Children will be assumed to have been harmed or to be at risk of harm when their parent or carer has been a victim of domestic and family violence.*[13]

Being the victim of domestic and family violence can have detrimental impacts on children's physical and mental wellbeing, cognitive development, behaviour and schooling.[14]

[12] Department of Children, Youth Justice and Multicultural Affairs 2022, *Child Safety Practice Manual—Safe and together model,* https://cspm.csyw.qld.gov.au/practice-kits/domestic-and-family-violence/overview-of-domestic-and-family-violence/safe-and-together-model

[13] DCYJMA 2022, *Child Safety Practice Manual—Domestic and family violence practice kit*, https://cspm.csyw.qld.gov.au/getmedia/702aaa8a-7e81-4126-9f3a-5ac9e93a9926/Domestic-and-family-violence-2022-02-23.pdf

[14] Campo M 2015, *Children's exposure to domestic and family violence: Key issues and responses,* Australian Institute of Family Studies (CFCA Paper no. 36), https://aifs.gov.au/cfca/publications/childrens-exposure-domestic-and-family-violence

*Children and young people who experience domestic violence and other forms of child maltreatment are more likely to exhibit internalising and externalising behaviour problems, as a result of the perpetrator's harmful patterns and violent examples. Practitioners must be mindful to assess children's behaviours by paying attention to the wider traumatic context that the perpetrator established.*[15]

Through an analysis of the sample cases, the CDRB considered several recurring issues relating to system responses to children and families experiencing domestic and family violence.

#### 3.1.1. Children's and families' experiences

Domestic and family violence is often co-reported with concerns about parental alcohol and other drug use and mental health issues in reports of child abuse or neglect.[16,17] However, it is noted that by virtue of their involvement with the child protection system, more information is captured on the issues experienced by these families.

Among the sample cases, many children and families reportedly experienced other challenges in addition to domestic and family violence.

*Table 1:Commonly reported parental factors*[18]

| Presence of: | Count | Percentage (n=43) |
|---|---|---|
| Substance use | 38 | 88.4% |
| Mental health concerns | 37 | 86.0% |
| Financial stress or homelessness | 30 | 69.8% |

Figure 1 indicates the frequency with which multiple factors were present within individual cases. All three factors were identified in over half of the cases (53.4%, n=23). At least one factor was present in each case.

[15] Heward-Belle S, Healey L, Isobe J, Roumeliotis A, Links E, Mandel D, Tsantfski M, Young A & Humphreys C 2020, *Practice Guide: Working at the intersections of domestic and family violence, parental substance misuse and/or mental health issues.* https://www.nifvs.org.au/wp-content/uploads/2021/03/STACY-Practice-Guide.pdf

[16] Australia's National Research Organisation for Women's Safety 2021, Critical interpretive synthesis: Child protection involvement for families with domestic and family violence, alcohol and other drug issues, and mental health issues, https://www.anrows.org.au/publication/critical-interpretive-synthesis-child-protection-involvement-for-families-with-domestic-and-family-violence-alcohol-and-other-drug-issues-and-mental-health-issues/

[17] Humphreys C, Kertesz M, Parolini A, Healey L, Tsantefsk, M, Heward-Belle S, O'Leary P, Isobe J, Tan WW, Jeffreys C, Bornemisza A, Young A & Fogden L 2020, *Safe & Together Addressing ComplexitY for Children (STACY for Children),* https://www.anrows.org.au/project/stacy-forchildren/

[18] The reported count relates to individual child deaths and does not indicate occasions where both the offending and non-offending parent experienced these factors.

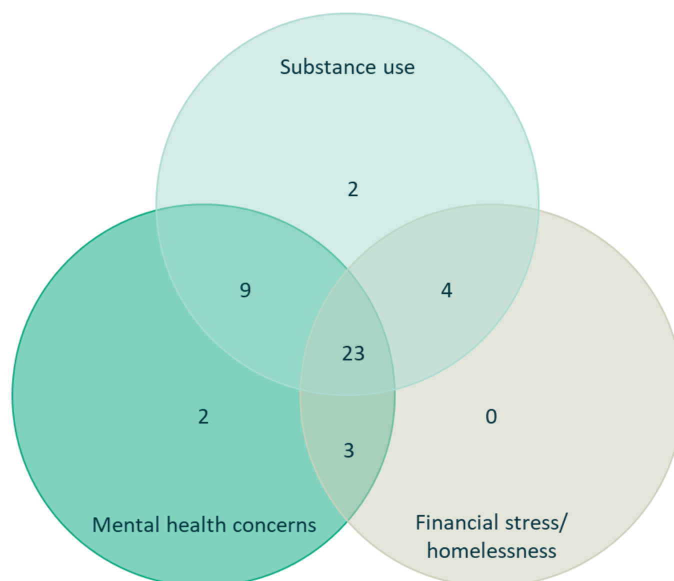


***Figure 1**: Prevalence of multiple factors within sample cases*

The overlapping factors and competing needs that families experienced potentially impacted subsequent interactions with the system—such as their ability to engage with services or programs intended to address domestic and family violence (see 3.1.5 'Engaging families with supports').

### 3.1.2. Risk assessments

There were widespread concerns about the system's understanding and assessment of the risks posed by domestic and family violence to children and non-offending parents—this was the most commonly cited issue across CDRB and agency reviews. This related to risk assessment processes (such as gaps in gathering evidence or information) and outcomes (such as inaccurate understandings of risk factors).

#### Gaps in evidence

domestic and family violence can take many forms, often with multiple types of violence occurring simultaneously. Within the sample cases, evidence of emotional harm was most frequently reported, representing 97.7 percent of the sample cases. This included behaviours used to torment, intimidate, harass or offend the other parent (for example, threats to suicide, harassing text messages or regularly name calling and belittling). This was followed by evidence of physical violence (90.6%) (for example, punching, kicking or slapping, non-lethal strangulation or assault with weapons and household objects). The high prevalence across categories mean that multiple forms of violence were commonly experienced together.

Evidence of sexual violence, including sexual assault, unwanted sexual behaviour or intimidation and sexual comments, was only observed in nine cases (20.9%) (for example, reports of rape and sexual assault). However, sexual assault is often under-reported and may be more common than shown in this sample.[19]

Perpetrators of domestic and family violence can use physical, sexual or emotional abuse, or threats, as a means of asserting control and manipulation.[20] Coercive control was observed in cases where other forms of violence were used (for example, threats to kill the children if the other parent left, isolating the other parent or excessive monitoring causing the other parent to become fearful)

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[19] Australian Law Reform Commission 2010, *The prevalence of sexual violence*, https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/24-sexual-assault-and-family-violence-2/the-prevalence-of-sexual-violence/

[20] Women's Safety and Justice Taskforce, *Options for legislating against coercive control and the creation of a standalone domestic violence offence—Discussion Paper 1 Summary*, womenstaskforce.qld.gov.au/__data/assets/pdf_file/0003/686415/Discussion_paper_1_SUMMARY.pdf

*Table 2: Type of violence reported by agencies*

| Type of violence | Count | Percentage (n=43) |
|---|---|---|
| Emotional | 42 | 97.7% |
| Physical | 39 | 90.6% |
| Sexual | 9 | 20.9% |
| Coercive control | 35 | 81.4% |

The CDRB observed recurring commentary in agency review reports about the invisible nature of much domestic and family violence, with reference to incorrect assumptions that 'absence of evidence equaled evidence of absence'—that is the lack of evidence was incorrectly used to determine that violence had not occurred or did not result in harm. This was demonstrated where decisions to close interventions or not act in response to new concerns about violence were justified on:

- a lack of police callouts in relation to violence
- limited history of reported incidents, or a lack of new or recent incidents
- no reported evidence that children had been physically harmed by incidents.

These assumptions do not reflect the under-reported nature of much domestic and family violence—particularly in circumstances where mothers had voiced fears of Child Safety becoming involved if they reported violence, or occasions where fathers influenced agencies' perceptions of the violence.

Moreover, there was evidence of non-physical forms of violence not being considered in cases where the system over-relied on the absence of evidence of physical violence (such as bruises on children or reports of physical violence to police). However, of the cases where physical forms of violence were not identified, there were significant concerns about other controlling behaviours, such as stalking and harassment, kidnapping children, verbal and emotional abuse and destruction of property.

At times, agencies' records included vague comments about 'domestic and family violence being a worry' or reference to 'domestic violence incidents'. These statements did not differentiate the type of violence used or determine accountability.

The case analysis revealed occasions where decisions about harm (or risk of harm) minimised the impact of domestic and family violence on children. For example:

- agencies not reporting relevant incidents to Child Safety
- limited consideration of the impact for all children living in a home where violence was present, regardless of their age or their relationship to the perpetrator
- agencies neglecting to consider all types of harm, including:
  - focusing on emotional harm and not exploring the risk of physical harm to the child (such as when children were being held by parents during violent incidents or when parents had made threats to physically harm children)
  - focusing on evidence of physical harm to children (including bruising), without consideration to the emotional impact of ongoing violence within the household and potential cumulative harm.

There is growing understanding that domestic and family violence is not limited to physical violence, and this is reflected in its legal definition (*Domestic and Family Violence Protection Act 2012* (Qld)). However, non-physical violence may not always be obvious to professionals responding to families, making it important to understand and map behaviours and risk factors. Research has established risk factors that are indicative of serious injury or death

in the context of domestic and family violence—referred to as lethality indicators. The prevalence of these across the case sample is discussed at section 3.1.4 'Recognising and responding to lethality indicators'.

In addition, reviews cited training and staff supervision as important for supporting strong risk assessments in the context of domestic and family violence. This included the need to embed cultural considerations into guidance and training and acknowledge the strengths within Aboriginal and/or Torres Strait Islander communities to address violence.

#### Listening to children's voices

The case analysis revealed occasions where the voice of the child and their needs were at times lost in a system heavily focused on responding to their parents.

Children were not always interviewed as part of investigations when they were of an age appropriate to be interviewed, despite their experiences of domestic and family violence. This denied children the right for their experiences to be heard and their needs to be identified. It also impacted the quality of information gathered to inform safety and risk assessments.

Where children were interviewed, there were, on occasion, critical errors with the way in which interviews were undertaken. For example:

- children were interviewed in the home with the offending parent present, impacting the ability of children to respond freely and openly
- assessments were based on only one or very limited interviews in the family home, rather than trying to engage with a child at school or another place of safety
- agencies focused on enquiring about mother's presentation and coping ability with minimal questions about the children's experience of home-life and what they had witnessed.

In the absence of specific disclosures of violence by children, agencies must pay attention to what a child and young person's behaviours might be telling them and be curious about what might be preventing a child from speaking up. This was not always evident across cases.

***Case example***

*During an interview about a violent incident that had occurred several weeks prior, a child was reportedly 'not distressed' by the incident and appeared to have 'brushed it off'. This was cited as evidence in support of withdrawing system contact with the family.*

*In this case, there was a missed opportunity to engage with the child around their emotional wellbeing in light of multiple reports of physical violence and threats to kill within the household and reports that the child was visibly distressed and fearful of the offending parent.*

Assessments of children must go beyond their physical appearance and generalised observations about whether they appeared fearful around the perpetrating parent or appeared to be meeting their milestones.

***Case example***

*In reflecting on service delivery to a child, a review report recognised the difficulty of relying on observations from a brief interaction with a child was that it minimised and failed to acknowledge the child was impacted or traumatised by their experience of living with domestic and family violence.*

*In this case, the potential cumulative harm was not considered as the children had not overtly stated what they had witnessed and how it made them feel. Believing that children who present as well-dressed and 'happy' at the time of interview, and who do not disclose violence, does not confirm they have not been impacted and are not at risk.*

### 3.1.3. Information sharing

Cross-sector collaboration is increasingly viewed as an indicator of best practice for working with children and families affected by domestic and family violence,[21] particularly given the comorbidity of risk factors observed among perpetrators of violence and need to maintain their visibility across agencies or sectors to address their behaviours and risks they pose to children.[22] It is seen to have benefits for improving responses and making it easier for families to navigate through different systems (for example, by reducing duplication of effort and avoiding overlap between different systems).

Several review reports commented on the missed opportunities for agencies to share/gather information to correctly identify domestic and family violence and provide a coordinated response. This included instances of:

- information not being shared with secondary support services to inform their engagement with the family
- incomplete information sharing between multiple government agencies responding to the family simultaneously
- information not being gathered from other agencies to clarify or confirm reports or allegations made by parents about the violence and impact on children's safety and wellbeing.

At times, this meant decisions about children's safety and subsequent responses were made based on incomplete information. Review reports also reflected on missed opportunities to refer children to multi-agency teams (including Suspected Child Abuse and Neglect (SCAN) teams or High-Risk Teams) given the complexity of child protection concerns and need for multi-agency discussion and coordinated actions.[23] Three cases were referred to a High-Risk Team and eight to SCAN (including a case which was referred to both). Where multiple agencies are involved with a family in relation to domestic and family violence, strengthened information sharing will assist all agencies to assess and respond to children's needs and safety, particularly when they are outside High-Risk Team catchments or do not meet the threshold for a referral.

The literature review (**Attachment A, section 4**) highlights several individual and organisational barriers to cross-agency/cross-sector communication and collaboration, such as differing service delivery paradigms, capacity for collaborative work, lack of supportive leadership and lack of common understanding of risk factors. The use of shared frameworks or protocols and shared training about risk factors are two areas where research indicates some positive improvements with cross-agency collaboration in child protection contexts.

### 3.1.4. Recognising and responding to lethality indicators

Mapping perpetrators' behaviours and recognising lethality indicators (factors indicative of serious injury or death) is a key step in seeking to understand the risk of harm to children.

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[21] Zannettino L & McLaren H 2014, 'Domestic violence and child protection: Towards a collaborative approach across the two service sectors', *Child & Family Social Work*, 19(4), 421-431.

[22] Herbert J, Ghan N, Salveron M & Walsh W 2021, 'Possible factors supporting cross-agency collaboration in child abuse cases: A scoping review', *Journal of Child Sexual Abuse*, 30(2), 167-191.

[23] High Risk Teams (HRT) were established across eight sites in Queensland following recommendations made in the *Not Now, Not Ever* report. The intention of HRT is to provide an innovative and integrated service response which ensures the coordination of services and supports across government, and non-government services to improve the safety of domestic and family violence victims and their children, while holding perpetrators accountable.

While the presence of a lethality indicator does not reliably predict that a parent will harm their child or partner, the more indicators present and the more severe the behaviours, the more urgently agencies should act on the possibility that the perpetrator will harm or kill. This should be a key consideration when assessing the risk of harm to children but is not always the case.

*While recognising lethality indicators differ across agencies, there are several indicators which are consistently reported across agencies' risk assessment procedures. For this project, Child Safety's lethality indicators (as reported in the Child Safety Practice Manual) were used. This includes 12 possible lethality indicators.*

*Details of these are available in* ***Appendix B.***

More than 80 per cent of the sample cases included evidence of three or more (out of a total of 12) lethality indicators within the child's family or household (such as non-lethal strangulation, violence during pregnancy, threats to kill, or threats to suicide) and over half (55.8%, n=24) included evidence of five or more.

*Table 3: Number of lethality indicators identified*

| Number of lethality factors | Count | Percentage (n=43) |
|---|---|---|
| 1 or more | 43 | 100.0% |
| 3 or more | 35 | 81.4% |
| 5 or more | 24 | 55.8% |
| 7 or more | 14 | 32.5% |
| 9 or more | 7 | 16.3% |

The case analysis revealed multiple instances where perpetrator behaviours were not mapped well, and lethality indicators were not identified or understood by responding agencies.

In several cases, lethality indicators were incorrectly assumed to be protective factors which would promote the safety of non-offending parents and children. This was highlighted through misconceptions about relationships ending, and fathers (or partners) leaving the home being an indicator of safety. In these cases, decisions to end agency involvement with the family were in part attributed to planned or recent separation based on assumptions that if mothers were safer, children would also be safer.

***Case example***

*Comments recorded by an agency suggested that the child's parents' separation was considered a protective factor and was used, in part, to support subsequent decision making about the child's safety.*

*This commentary failed to recognise separation as a risk factor or plan for the child's ongoing safety, particularly in the context of multiple other lethality indicators (such as breaches of Domestic Violence Orders, non-lethal strangulation, stalking, recent injuries causing hospitalisation and escalation of violence).*

*Shortly after, the father was in contact with the mother again.*

This assumption does not reflect that children's experiences of domestic and family violence do not always end when parents separate, particularly where violence continues through the separation, perpetrators remain in the

home following separation or children are used as an extended tool of power and control by the perpetrator.[24] Separation can also be a period of increased risk for domestic and family violence homicides. When considering the presence of separation in domestic and family violence homicides between 2006–07 and 2018–19, the DFVDRAB found that actual or pending separation was a feature in approximately one-half of intimate partner and collateral homicides, but was less prevalent in family homicides.[25] While the majority of homicides do not occur in the context of known separation, relationship breakdowns can pose a risk to both children and non-offending parents. This should be considered when making decisions about children's ongoing safety. Similarly, perpetrators actions or behaviours are important when they enter new relationships and are likely to have contact with their next partner's children.

In other cases, information about potential lethality indicators was not appropriately shared or requested by agencies to explore the risks these posed to children. Where this information was not known, decisions and actions relating to children's safety were made based on incomplete information.

Threats to harm or kill children was another lethality indicator regularly observed across the sample cases. However, threats were not always considered credible or explored further by seeking additional information from other involved agencies. Threats to kill or harm children may suggest that a child is at risk—particularly in the context of domestic and family violence, parental substance use, mental health concerns and other parental risk factors.

***Case example***

*A mother and her children were subject to threats to kill by mother's partner. These threats occurred in the context of ongoing physical violence against the mother, planned separation and her partner's mental illness and substance use. In this case, seven lethality indicators were present.*

*In this case, there was a missed opportunity to explore the credibility of the threats to kill—particularly in the context of domestic and family violence, substance use and mental health concerns—and seek information about the mother's partner's mental illness and substance use and his engagement with health services to support and manage this.*

Almost all cases also included evidence of other factors associated with increased risk in the context of domestic and family violence (such as hostage taking, mental illness, alcohol and other drug use or repeated calls to police) (see **Appendix B** for further details). The majority of cases (76.7%, n=33) included at least three of these risk factors. Only one case did not have any observable risk factors—and this may be due to gaps in available evidence.

*Table 4: Number of high-risk factors identified*

| Presence of: | Count | Percentage (n=43) |
|---|---|---|
| 1 or more risk factors | 42 | 97.7 % |
| 2 or more risk factors | 38 | 88.4% |
| 3 or more risk factors | 33 | 76.7% |

[24] Bagshaw D, Brown T, Wendt S, Campbell A, McInnes E, Tinning B & Fernandes Arias P 2011, 'The effect of family violence on post-separation parenting arrangements: The experiences and views of children and adults from families who separated post-1996 and post-2006', *Family Matters (no. 86) Australian Institute of Family Studies;* Meyer S 2014, 'Victims' experiences of short- and long-term safety and wellbeing: Findings from an examination of an integrated response to domestic violence', *Trends and Issues in Crime and Criminal Justice Series (no. 478), Australian Institute of Criminology.*
[25] Domestic and Family Violence Death Review and Advisory Board 2019, *Annual Report 2018–19,* https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/630159/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2018-19.pdf

| 5 or more risk factors | 15 | 34.9% |
|---|---|---|
| 7 or more risk factors | 4 | 9.3% |

19 cases (44.2%) had a combined total of ten or more lethality indicators and risk factors, with one case involving all 20 (12 lethality indicators and eight other high-risk factors).

Agencies responding to concerns about domestic and family violence have a responsibility to be aware of children's experiences or risk of harm, including any risks posed by lethality indicators or other risk factors. Where these are present, practitioners must apply their professional judgement to assess the risk and respond appropriately to help keep children safe.

#### 3.1.5. Holding perpetrators accountable

Historically, parental responsibility for protecting children and preventing violence has been placed on mothers due to gendered perceptions of women as primary carers.[26] More recently, a focus on 'holding perpetrators accountable' has dominated policies and practices designed to reduce or prevent domestic and family violence, such as the rollout of the Safe and Together model throughout Queensland.

However, perpetrator accountability is not well defined,[27] nor was it within the scope of this project to define the term. Generally, accountability can be operationalised by the child protection system through:

- language used to describe behaviours and violence
- referrals to supports or interventions
- actions (legal or procedural) taken in response to perpetrators' behaviours.

In three-quarters of the sample cases, a male caregiver was considered to be the primary perpetrator[28] of violence (74.4 per cent of cases). While there was some evidence of female caregivers, both caregivers, subject children and other family or household members (such as grandparents) perpetrating violence, this was less common.

*Male caregivers included fathers, stepfathers, mothers' partners or fathers of siblings, and were involved in caring for children within the household. At times, more than one male caregiver was reportedly perpetrating violence against a female caregiver (such as a father and mother's partner).*[29]

*Where female caregivers were identified as perpetrating violence, this included mothers.*

The case analysis highlighted recurring issues with the system holding offending parents accountable. This was directly identified by review agencies or the CDRB in over half of the cases. This was observed through:

- offending parents not included in investigations, ongoing interventions or referrals to secondary services despite their ongoing presence in the household and responsibility in caring for their children
- actions or decisions which did not consider the offending parents' role in parenting and consideration of the impact of their use of violence on the household

[26] Humphreys C & Absler D 2011, 'History repeating: Child protection responses to domestic violence', *Child & Family Social Work*, vol. 16, issue. 4, pp. 464–473.
[27] Australia's National Research Organisation for Women's Safety 2020, *Improved accountability: The role of perpetrator intervention systems (issue no. 20),* https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/Chung-RR-Improved-Accountability.pdf
[28] Primary perpetrator refers to the person who was alleged responsible in agency review reports and supporting materials.
[29] The reported count relates to individual child cases. Cases where multiple male caregivers reported to have perpetrated violence were only counted once.

- no follow-up with offending parents who had left the household or were not present when agencies responded to the violent incidents
- over-reliance on offending parents agreeing to address violence, without interventions or supports put in place by the system.

In several cases, review reports reflected that risk assessments had not been undertaken with the primary parent who posed the risk despite their ongoing role in caring for the children. This meant that important details about the offending parent's violent behaviours were not known or used to inform subsequent decisions about children's safety.

***Case example***

*Agencies were aware that a mother's violent partner was living in the home and involved in caring for her children. However, critical checks about his criminal, domestic and family violence and child protection histories, and assessments about the risks this posed to the children were not undertaken.*

*This meant that information about the violence he had perpetrated against previous partners, the details of his current Domestic Violence Order, or information that his own children had been placed on child protection orders, was not considered when determining whether the children would be safe in his care.*

***Case example***

*While living with an extended family member (their carer), a child had ongoing communication and interaction with their mother, particularly during periods that their carer left town. The mother perpetrated violence against the carer and her child, resulting in a Domestic Violence Order being issued with no contact conditions.*

*When determining whether the child was safe, the system could have given greater consideration to the ongoing role that the mother had in her child's life and the impact of the violence that she was perpetrating against the carer and the child.*

In the absence of engagement with offending parents, more focus is typically placed on non-offending parents. This was evident through the case analysis in circumstances where agencies relied on non-offending parents as the only parent responsible for the protection of the children and their ability to address the violence and protect the children, without addressing the threat posed by offending parents. While observed infrequently across the sample this also meant that at times agencies adopted approaches that did not hold offending parents accountable for using violence against the other parent and children. Where agencies adopted gender-based language to discuss domestic and family violence and assign blame to non-offending parents, review reports accurately reflected the need to strengthen frontline workers' understanding of violence and training in models such as Safe and Together.

***Case example***

*A mother reported that her child's father was violent and controlling, including making threats to harm her and take her child. In this case, the mother was held responsible for conversations she needed to have with the father about the violence, rather than the agency attempting to locate and engage father, hold him accountable and identify the interventions or support needed.*

There are local level responses that seek to address the gendered approach to responding to child protection and domestic and family violence concerns. For example, the Walking with Dads program provides an opportunity for a specialist worker to increase the safety of mothers and their children by working with fathers known to Child Safety

to change behaviour and take responsibility for the impact of their behaviour on their children. While there was limited evidence of this program being utilised among the sample cases (two cases made reference to the program), where it was used, staff reflected that it had offered valuable insights to inform interviews with parents and case decisions about ongoing safety for children. In one case where it was used, staff had mapped the offending parent's behaviours and identified several lethality indicators and the risks that this posed to the children.

#### 3.1.6. Engaging children and families with supports

Within the Queensland child protection system, referrals to secondary service providers play an integral role in protecting children by providing supports and building the ability of their parents to keep them safe. However, service delivery is limited by the level of uptake and engagement.

Across the sample cases, there was widespread use of referrals to secondary support services in relation to multiple family needs, such as mental health supports, substance use interventions and family or parenting support. The below table shows referrals by agencies to secondary service providers in relation to domestic and family violence supports occurred in 27 cases (62.8%) within the year prior to the child's death.

*Table 5: Referrals to secondary services for domestic and family violence support or intervention*

| Referrals to services | Count | Percentage (n=43) |
|---|---|---|
| All service involvement types, including: | 27 | 62.7% |
| • domestic and family violence specialist services only | 15 | 34.9% |
| • FaCC (for domestic and family violence) only | 3 | 6.9% |
| • Both domestic and family violence specialist services and FaCC (for domestic and family violence) | 9 | 20.9% |

Of the 27 cases that were referred for support, most were referred directly to a domestic and family violence specialist service (such as Brisbane Domestic Violence Service or DV Connect). The Queensland Police Service were the main referrers to these services. Three cases (6.9%) were referred only to a Family and Child Connect (FaCC) for violence concerns. FaCC can provide families with general information and advice or refer families on to required services (such as specialist services). Nine cases (20.9%) were referred to both a specialist service and a FaCC. Referrals were calculated per case, rather than per parent or per referral (such as in circumstances where families were referred to FaCC twice).

However, rates of service engagement among the sample cases were low. Of the total 27 cases referred to a secondary support service, less than half showed evidence of engagement.

Several barriers which may have impacted service engagement were identified, including:

- waitlists
- fear that engaging with services or disclosing violence would result in further involvement by Child Safety
- referrals to mainstream services without consideration of culturally appropriate options
- relocation of families, and absence of agency follow-up to determine if supports are required in their new community.

***Case example***

*A father was supported to call a men's perpetrator program operated through a domestic violence service. The service indicated that there would be a four-week wait until the next intake. Agencies closed their*

*involvement with the family on the basis that the mother and father were engaging in support services, and planned to engage with the referred perpetrator program.*

*Subsequent information indicated that the father had not engaged with the program.*

Some families were also referred to Intensive Family Support service or Family Wellbeing Services, although it was not always clear from agency records whether this was in relation to domestic and family violence and there was limited evidence of meaningful service engagement among these referrals. For example, one family was noted to 'not engage well' and refused to engage with the violence specialist within the service.

There are multiple barriers which impact parents' engagement with services—such as past negative experiences with services, stigma/shame, fear of punitive responses and practical barriers (including time, service location, proximity to public transport, service costs and provision of childcare).[30] Although less is known about the factors that impede or facilitate fathers' engagement with services than mothers.

Furthermore, as was the case for majority of families considered in this review (see Figure 1), families who experience multiple or complex needs are likely to prioritise basic or 'survival' needs over service engagement.[31] Consequently, parents may be unable to effectively engage with domestic and family violence interventions or services until their more basic needs have been addressed. Research on the barriers and enablers for effective service engagement are described in **Attachment A**.

### Culturally responsive services

Agencies commented on parents 'avoiding' or 'not engaging well' with referred services in several cases relating to Aboriginal and/or Torres Strait Islander children without further exploration of the reasons that families may choose not to engage. At times, these families had been referred to mainstream family support services without discussion with the family about whether services run by local Community-Controlled Organisations may be more appropriate.

For Aboriginal and Torres Strait Islander families who experience domestic and family violence, engagement is likely to be facilitated by approaches that take into account historical circumstances such as colonisation, dispossession and a legacy of socioeconomic disadvantage.[32]

As described in the Family Matters Report:

> *"The existence of family violence in Aboriginal and Torres Strait Islander communities today is closely linked to the violence and trauma of colonisation—including the attempted wholesale destruction of Aboriginal and Torres Strait Islander cultures—and evidence suggests that culture is a key protective factor that both supports families to be free of violence and helps victim survivors to heal from violence".*[33]

Aboriginal and Torres Strait Islander Community-Controlled Organisations are funded by the Queensland Government to deliver Family Wellbeing Services and the Family Participation Program to assist Aboriginal and/or Torres Strait Islander children and families in decision-making process and to access culturally safe and responsive supports. Family Wellbeing Services are reportedly overwhelmed supporting the needs of families, including

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[30] See Attachment A; Schock AM & Gavazzi SM 2004, 'A multimethod study of father participation in family-based programming. In RD Day & ME Lamb (Eds.), *Conceptualizing and Measuring Father Involvement*. pp. 129–159. Routledge: New York; Ghate D, Shaw C & Hazel N 2000, *Engaging Fathers in Preventive Services: Fathers and Family Centres*. Joseph Rowntree Foundation, York; Soriano G, Clark H & Wise S 2008, *Promising Practice Profiles Final Report*. Australian Institute of Family Studies: Melbourne; Spoth R, Redmond C, Hockaday C & Shin C 1996, Barriers to participation in family skills preventive interventions and their evaluations: a replication and extension. *Family Relations*, 45, pp. 247-254.

[31] See Attachment A; Carbone S, Fraser A, Ramburuth R & Nelms L 2004, Breaking cycles, building futures. Promoting inclusion of vulnerable families in antenatal and universal early childhood services: a report on the first three stages of the project. Victorian Department of Human Services: Melbourne

[32] Meyer S & Stambe R 2020, 'Mothering in the context of violence: Indigenous and non-indigenous mothers' experiences in regional settings in Australia', *Journal of Interpersonal Violence*, *37*,

[33] SNAICC 2021, *The Family Matters Report 2021*, https://www.familymatters.org.au/wp-content/uploads/2021/12/FamilyMattersReport2021.pdf

responding to high levels of domestic and family violence.[34] In 2019, the Department of Children, Youth Justice and Multicultural Affairs also funded five specialist positions within Aboriginal and Torres Strait Islander Family Wellbeing Services in trial sites across Queensland. Sites were selected due to violence being the primary reason for child protection involvement with Aboriginal and Torres Strait Islander families in these sites.[35]

Several review reports reflected that involving a Family Wellbeing Service would likely have been beneficial and more successful in engaging with families than referrals to mainstream services. As described in one review report:

> *"… the involvement of a Family Wellbeing Service would have greatly benefited the family to access culturally responsive support…records indicated that the family (particularly Mother) were fearful of engaging with [the agency] and a sense of safety may have enabled Mother to more openly discuss the domestic and family violence she had endured for decades in her relationship. A culturally appropriate support service may have enabled Mother and Father to safely engage and build their capacity to safely care for their children".*

In other cases, families who were referred to these programs were reported to be hesitant to engage due to concerns with trust and information about them being shared with the broader community.

### Engaging offending parents with services

Of the cases where service engagement was observed, this was in relation to female caregivers as the non-offending parent. No service engagement by male caregivers as the offending parent was reported by agencies.

Fatherhood may be a significant motivator for encouraging men to accept accountability for their actions and change their behaviour.[36] Their motivation to attend behaviour change programs often centres around improving their parenting and relationships with their children.[37] While research on fathers' engagement is relatively scarce, evidence suggests that tapping into a man's desire to be a better father may be an effective means through which to address his use of domestic and family violence.[38]

As discussed in the literature review (see **Attachment A, section 1**), there are three broad types of interventions aimed at men who perpetrate domestic and family violence: men's behaviour change programs (MBCPs), fathering programs for men who perpetrate violence, and healing programs.

Perpetrator interventions are not always connected to legal processes (for example, agencies can refer a father to a perpetrator program without involvement of the criminal justice system), and the extent to which program

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[34] ANROWS 2022, *New ways for our families: Designing an Aboriginal and Torres Strait Islander cultural practice framework and system responses to address the impacts of domestic and family violence on children and young people,* https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/04/Morgan-et-al-RR1_NewWaysOurFamilies.pdf

[35] ANROWS 2022, *New ways for our families: Designing an Aboriginal and Torres Strait Islander cultural practice framework and system responses to address the impacts of domestic and family violence on children and young people,* https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2022/04/Morgan-et-al-RR1_NewWaysOurFamilies.pdf

[36] Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work*, *23*, 97–104.; Broady TR, Gray R, Gaffney I & Lewis P 2017, 'I miss my little one a lot': How father love motivates change in men who have used violence', *Child Abuse Review, 26*(5), 328–338.; Casey EA, Leek C, Tolman RM, Allen CT & Carlson JM 2017, Getting men in the room: Perceptions of effective strategies to initiate men's involvement in gender-based violence prevention in a global sample', *Culture, Health & Sexuality, 19*(9), 979–995.; Stanley N, Graham-Kevan N & Borthwick R 2012, 'Fathers and domestic violence: Building motivation for change through perpetrator programs'. *Child Abuse Review, 21*(4), 264–274.

[37] Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work*, *23*, 97–104; Pennell J, Rikard RV & Sanders-Rice T 2014, 'Family violence: Fathers assessing and managing their risk to children and women' *Children and Youth Services Review, 47*(1), 36–45; Stanley N, Fell B, Miller P, Thomson G & Watson J 2012, 'Men's talk: Men's understandings of violence against women and motivations for change', Violence Against Women, 18(11), 1300–1318.; Stanley N, Graham-Kevan N & Borthwick R 2012, 'Fathers and domestic violence: Building motivation for change through perpetrator programs'. *Child Abuse Review, 21*(4), 264–274.

[38] Carlson J & Casey EA 2018, 'Perceptions of men who have perpetrated intimate partner violence on creating a transition to fatherhood program', *Journal of Family Violence*, *33*(7), 457–468.; Humphreys C & Campo M 2017, *Fathers who use violence: Options for safe practice where there is ongoing contact with children*. Australian Institute of Family Studies: Melbourne.; Meyer S 2018, 'Motivating perpetrators of domestic and family violence to engage in behaviour change: The role of fatherhood', *Child & Family Social Work*, 23, 97–104.

attendance or participation is followed up can vary.[39] Generally, uptake of perpetrator behaviour change programs is low, and an even smaller number complete programs.[40] In several of the sample cases, perpetrators initially agreed to referrals but either did not engage, or agencies did not follow-up to determine whether they had engaged. In two cases, it was noted that perpetrators were believed to be engaging in a behaviour change or anger management program as a condition of corrections order,[41] however, there was no evidence of agency follow-up to confirm this.

While fatherhood can be a significant motivator for encouraging men to accept accountability for their actions and facilitate behaviour change, most men's behaviour change programs (MBCPs) do not directly address fathering practices, seek to change behaviours that can impact on the father-child relationship and undermine mothers' parenting ability or include children's perspectives and participation. While fathering programs for men who use domestic and family violence encourage improvements in parenting/co-parenting skills, there is limited evidence as to whether programs affect violent behaviours or child outcomes—especially over the longer term.

Research on healing programs note that for these programs to be effective at engaging participants, they must be culturally competent, sensitive to historical context, trauma-informed, be co-designed, community-owned and community-led, and incorporate linkages and wraparound support models.[42]

### Children who display high-risk, violent or aggressive behaviours

Children who have experienced domestic and family violence are at greater risk of using violent behaviours in their own relationships or be victim to intimate partner violence as adults. [43] However, across the sample cases, system referrals to services focused on parents, with the assumption that this can improve circumstances and allow them to better care for their children.

Almost one-third of the sample cases included evidence of subject children and/or their siblings using violent or aggressive behaviours. Among some younger children, there was evidence of violent and aggressive behaviours between siblings, verbal and physical aggression and self-harming behaviours.

While limited to a few cases, there was also evidence of adolescents using violent towards their partners or mothers. All of these adolescents experienced domestic and family violence throughout their childhoods—perpetrated by their fathers against their mothers. However, the system struggled to respond to young people who were both perpetrators and victims of violence. Agencies reported a lack of policies or programs specific for responding to young people who use violence, resulting in evidence of young people not receiving intervention or support or assumptions that they could access their own supports if needed.

Stopping the intergenerational transmission of domestic and family violence requires that the impact of on children is identified and responded to early.[44] The system must remain alert to the harm caused by experiences of violence and target early interventions appropriately. Reviews reflected on the need to address this gap and deliver responses that recognised the impact of intergenerational trauma and supported healing.

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[39] ANROWS 2022, *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews,* https://apo.org.au/node/316299

[40] ANROWS 2018, *Invisible Practices: Intervention with fathers who use violence—Key findings and future directions,* https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2020/08/Healey-et-al-RtPP-Invisible-Practices.2.pdf

[41] Evidence to confirm this was out of scope of this review.

[42] The Healing Foundation and White Ribbon Australia (2017). *Towards an Aboriginal and Torres Strait Islander violence prevention framework for men and boys*, https://www.whiteribbon.org.au/awcontent/whiteribbon/documents/White-Ribbon-Australia-Towards-an-Aboriginal-and-Torres-Strait-Islander-violence-prevention-framework.pdf

[43] Royal College of Psychiatrists, *Domestic violence and abuse – the impact on children and adolescents,* https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/information-for-parents-and-carers/domestic-violence-and-abuse-effects-on-children

[44] Heward-Belle & Humphreys C 2021, *Stop the contagion of violence against women,* April 14 2021, Women's Agenda, https://womensagenda.com.au/latest/stop-the-contagion-of-violence-against-women/

### 3.1.7. Capability and capacity

Across the sample cases, the CDRB and agencies made recurring findings relating to the capability and capacity of the child protection system to respond to domestic and family violence, suggesting a focus on improving specialised frontline practices.

#### Recognition of cumulative harm

Multiple cases indicated the impact of limited capacity on thoroughly reviewing and considering children's experiences of domestic and family violence over time. This meant that cumulative harm caused by domestic and family violence could not be identified.

There was evidence of professionals taking an incident-based approach to decisions rather than a holistic consideration of the child's history and lifetime experiences of domestic and family violence. This could have indicated the risk of cumulative harm caused by ongoing experiences of adverse childhood experiences, including violence, and potential need for further action.

#### Lack of domestic and family violence-specialist knowledge

Review reports made recurring commentary about staff capability in relation to domestic and family violence practices, including:

- staff using outdated models, language or practices
- perceptions among staff that, because they had not undertaken Safe and Together training, they did not have the skills to provide meaningful responses.

Noting these varied experiences, Child Safety staff consistently expressed a desire for more Safe and Together training. However, barriers to deploying Safe and Together training were identified. In several cases, Child Safety Service Centres had previously received Safe and Together training but staff turnover had left a significant knowledge gap. For example:

> *In reflecting on who had previously completed the four-day Safe and Together training, the Region advised the majority of people were no longer employed by Child Safety. It was noted at present there were low numbers of staff who were presently employed who had completed this training.*

Concerns about capacity challenges were also cited to impact staff's ability to complete the Safe and Together training. However, it was noted that training alone would be insufficient. As described in one review report:

> *Whilst face-to-face training is important, a broader strategy for embedding practice knowledge and supporting a change in culture is also required to evidence practice change.*

These findings suggest that Safe and Together training is seen to be an integral part of the solution within Child Safety to improve domestic and family violence responses to families, but the training must be accessible, and strategies developed to retain collective workplace knowledge in light of the challenges posed by workforce turnover.

Several review reports included specific findings in relation to building capability in culturally appropriate ways of working with Aboriginal and Torres Strait Islander families experiencing domestic and family violence. This included engaging with appropriate community organisations and reflecting on the need for greater consideration of cultural protective factors in risk assessments processes.

#### Response to offending parents

Review reports also identified a specific gap in response to perpetrators. Agencies expressed a lack of understanding of perpetrators' behaviour, and uncertainty in how to appropriately engage and respond to this. Mapping

perpetrator behaviours was recommended to understand the risk to children, however evidence that this had been undertaken appropriately was limited. Some staff consulted as part of agencies' internal review processes voiced concerns that involving perpetrators in ongoing interventions would place the child a greater risk. For example:

> *[Staff] acknowledged the benefits of mapping perpetrator behaviours with both a mother and father to understand the impact of the perpetrator's behaviours on the family and holding the perpetrator responsible for their behaviour. However, in practice, [staff] advised that it is a very complex decision as there are worries that involving the father may increase risk and harm to a mother and the children.*

The further roll-out of Safe and Together and Walking with Dads training was suggested as a solution to help staff feel confident engaging with perpetrators.

# 4. System improvements

Ten child deaths prompted review agencies to make recommendations in response to findings about domestic and family violence practices and responses. The below summarises themes from these recommendations.

*Table 6: Themes from agency review report recommendations*

| Recommendation themes |
| --- |
| Increased staff training relating to domestic and family violence |
| Further embedding the Safe and Together principles in child safety officer's practice and tools |
| Strengthening understanding of perpetrator patterns of behaviour |
| Implementing mechanisms to improve the quality of intake information |
| Improving visibility of previous reports about child harm |

Several themes were apparent across recommendations, including to rollout further staff training and further embed Safe and Together principles. These themes speak to the need for greater capability in recognising, assessing, and responding to domestic and family violence.

In addition, some agency review reports reflected on immediate actions agencies had taken in response to their findings. This primarily related to actions or plans intended to deliver staff training in Safe and Together and risk assessments. Other actions included:

- working with a non-government organisation to better understand factors influencing parents' engagement with family support services
- developing a domestic and family violence safety planning tool, in conjunction with specialists, to inform immediate safety planning with mothers when a referral to a community service is declined
- increasing involvement of Walking with Dads workers in case consults
- developing a domestic and family violence action plan to support understanding and response to violence and increase partnerships
- deploying Aboriginal trainers to build staff's ability to apply cultural learning in risk assessment processes
- incorporating domestic and family violence mapping as a standard part of practice panel processes, including completing a Power and Control Wheel[45]

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[45] The Power and Control Wheel is a resource used by Child Safety officers to help identify the ways in which a mother is being controlled and abused. A copy of The Power and Control Wheel is available in the Child Safety Practice Manual, available online at: https://cspm.csyw.qld.gov.au/practice-kits/domestic-and-family-violence/risk-assessment/responding/resources

- providing education about when to refer to a High-Risk Team.

These actions suggest that review agencies have already taken some steps to embed learnings relating to domestic and family violence. However, the lack of consistency across regions, or across agencies, suggests that a coordinated response may be required.

## 5. CDRB focus areas

This report highlights recurring system issues in domestic and family violence practices and responses to children and families known to the child protection system based on an analysis of cases reviewed by the CDRB. While based on a small sample who share the similar experience of involvement with the child protection system, the findings present opportunities for improving identification and assessment of violence and the risk it poses to children, as well as to ensure investment and effort in addressing offending parents' behaviours are appropriately targeted.

Findings are summarised under the following three sections:

### RECOGNISE AND ASSESS

Key findings:

- All forms of domestic and family violence and lethality indicators are not always recognised or understood by agencies and therefore the associated risks to children may not be obvious.
- Children's voices and views are not always appropriately sought or heard when the system responds to parents—minimising the harm they may have experienced.
- Cross-agency collaboration and information sharing is important for maintaining 'visibility' of perpetrator behaviours, understanding and minimising risks their behaviours pose to children and addressing comorbid risk factors.

The case analysis highlighted that children experienced multiple types of domestic and family violence (with physical and emotional violence and coercive control often being co-reported). However, some types of violence were missed by agencies—this was reflected in vague statements about violence or a focus on evidence of physical violence and previously reported incidents. There was also evidence of harm (or risks) to children being missed or minimised, particularly where children were not interviewed appropriately, decisions about their safety were made based on incomplete information or risk assessments did not consider all types of harm caused by violence.

### RESPOND

Key findings:

- There are missed opportunities to hold offending parents accountable and address the risk their behaviours pose to children when they are not included in investigations or interventions.
- Domestic and family violence supports and services play a key role in supporting parents and children, however uptake is low. There are multiple individual and organisational barriers which can inhibit service uptake and engagement.
- Culturally- and trauma-informed pathways and service provision are needed to enhance support for First Nations families.
- 'Fatherhood' can be a significant motivator to encourage fathers to accept accountability and facilitate behaviour change, however fathering practices are not well embedded in men's behaviour change programs and there is limited formal evidence about the effectiveness of programs in improving outcomes for children.

- There are gaps in system responses to children and young people which recognise and respond to their violent or aggressive behaviours in the context of intergenerational experiences of domestic and family violence and trauma.

As highlighted by the sample cases, domestic and family violence rarely occurs in isolation of other factors—particularly parental substance use and poor mental health. Promising practices include strengthening intersections between violence, substance use treatment and mental health with a focus on children and keeping perpetrators 'visible' across the system.

Among the sample cases, system referrals to domestic and family violence services or support appeared to focus on parents, with the assumption that this would improve circumstances and allow them to better care for their children. Among these, there was low uptake of referred services—particularly by the offending parent—with several barriers identified for this. For some First Nations families, these barriers included referrals to mainstream services without discussions about culturally appropriate and informed options.

### BUILD CAPACITY

Key findings:

- Cumulative harm (caused by children's ongoing experiences of domestic and family violence) can be difficult to identify when staff have limited capacity to undertake thorough child protection history reviews.
- Limited knowledge or training can lead to responses that do not recognise complex factors that surround domestic and family violence and result in suboptimal responses to children and parents. Training (particularly in the Safe and Together model) is seen to be integral to the solution for supporting frontline staff to identify and respond to domestic and family violence. However, workforce capacity and turnover presents challenges for delivering training and retaining collective workplace knowledge.
- Individually, agencies have identified actions or recommendations for strengthening domestic and family violence responses, particularly in relation to delivering training and reviewing tools and practices.

A recurring issue reported by review agencies, and reflected in their recommendations, related to the capability and capacity of staff to respond appropriately to domestic and family violence. The case analysis highlighted the need for strong understanding of violence when assessing the risks it poses to children and to respond effectively in an environment where workers are experiencing high workloads. For example, there were instances of agencies not including offending parents in assessments or responses, language that placed sole responsibility on non-offending parents and risk assessments that did not consider cumulative harm caused by violence or seek to understand the impact of violence from children's perspectives. Cross-agency protocols and training are seen to be promising practices for improving collaboration and knowledge of the interface between domestic and family violence and child protection. While the rollout of promising programs and training continues, the system is faced with the challenge of retaining specialist knowledge in light of workforce turnover.

# Appendices

## APPENDIX A—METHODOLOGY

This project relied on existing reports and review materials prepared by agencies with responsibility for undertaking child death reviews (including the Department of Children, Youth Justice and Multicultural Affairs (Child Safety and Youth Justice), the Department of Education, Queensland Health, the Queensland Police Service and the Office of the Director of Child Protection Litigation) and the Child Death Review Board (CDRB). Agency review reports and materials were provided the CDRB under s245O of the *Child Protection Act 1999* (Qld). The below table indicates the number of reports received from agencies. Not all agencies were required to undertake reviews for all child deaths in the sample.

*Table 7: Number of reports received from review agencies*

| | Child Safety | Youth Justice | QPS | QH | DoE | DCPL |
|---|---|---|---|---|---|---|
| Review reports and supporting materials | 43 | 2 | 10 | 11 | 1 | 3 |

In addition, the project reviewed:

- CDRB reports for 36 cases (where a Level 2 or Level 3 review had been undertaken)[46]
- CDRB briefing notes for 7 cases (for Level 1s)
- CDRB minutes for all 43 cases.

Records were reviewed for information relating to descriptions of domestic and family violence, system responses to the violence, and findings, issues or recommendations reported by agencies and the CDRB.

Based on a preliminary analysis of recurring system issues, and direction from the CDRB at its November 2021 meeting, a literature review was procured to explore the following issues:

a) what is known about the effectiveness of domestic and family violence perpetrator interventions, particularly those aimed at fathers who are perpetrators of violence

b) enablers and barriers for engaging parents as victims or perpetrators in domestic and family violence services or interventions, giving consideration to working with families where other parental risk factors are also present (including poor mental health and/or substance use)

c) briefly, the use of domestic and family violence in the context of other common parental risk factors (particularly poor mental health and/or substance use) among families in contact with the child protection system

d) enablers and barriers for effective interagency collaboration and communication (particularly child safety, police and health agencies) to address domestic and family violence within vulnerable families.

e) specific consideration to the experiences of Aboriginal and Torres Strait Islander families and the needs and supports required across each of the above topic areas where research is available.

[46] The Chairperson applies a review categorisation framework to categorise each review into one of three levels (Level 1, 2 or 3). The review categorisation framework sets the standard terms of reference for all reviews to be considered by the CDRB.

## Limitations

This study is limited by its small, non-randomised population and sample size. The population was the total number of child deaths reviews by the CDRB, which commenced on 1 July 2020. All families came to be included in this population due to their shared tragedy of a child death. The CDRB recognises that such a small sample group, selected due to their shared experiences, limits the generalisability of this study to the broader Queensland population.

The sample contained sibling groups. As is the practice of Queensland's child death review process, all child deaths were given individual consideration. This meant some cases in the sample shared similar circumstances. This is particularly impactful when looking at services provided to the siblings or agency findings relating to responses to them and their families. This may skew the results for some measures.

Acknowledging these limitations, this paper highlights unique insights into the system responses to domestic and family violence across all child deaths known the child protection system and recurring system vulnerabilities that should be addressed. A repeat of this study, once the CDRB has a larger population to sample, may be worth considering.

## APPENDIX B—CHILD SAFETY LETHALITY INDICATORS AND RISK FACTORS

There are several factors that are known to be high-risk indicators of serious injury and death. The more lethality indicators present and the more intense or severe the behaviours are, the more you should act immediately on the possibility that the perpetrator will attempt to kill his partner, children or someone else.

The following tables include high-risk factors for lethality or serious injury and other general risk factors sourced from the Child Safety Practice Manual.[47]

| **High-risk factors for lethality and serious injury** | |
|---|---|
| **Lethality indicators** | **Considerations** |
| Separating: actual or attempting | Mothers are most at risk of lethality or serious injury in the time pending, during or immediately after separation, particularly in the first 6 months after separation. |
| Threats of homicide or suicide | All threats of homicide and suicide need to be taken seriously, even if the father has made these threats previously and has not harmed anyone. Threats of suicide are a high-risk factor for murder-suicide scenarios. |
| Stalking | This includes physically following, unwanted contact via phone, text or social media platforms, or any other form of surveillance. |
| Intimate partner sexual violence | This is any forced or unwanted sexual activity that occurs without consent. Sexual assault is a serious form of violence and demonstrates intent to control the victim. |
| Non-lethal Strangulation | Also referred to as choking, strangulation is one of the most lethal forms of domestic violence. When a victim is strangled, she may lose consciousness within seconds and die within minutes. Violent men often use strangulation to kill their victims. A 2008 study found victims of attempted strangulation are 7 times more likely to be murdered. |
| Possession of or access to weapons and previous assaults with weapons | Men who use violence and have access to weapons are more likely to cause serious injuries to their victims. Previous use of a weapon indicates a high risk of future serious violence. |
| Escalation of violence | Does the woman believe the violence is currently escalating? Mothers' assessment of their and their children's safety is an important indicator. Victims of domestic violence are the experts in their own safety. Most are clear about what will make them safer or unsafe. |
| Severity of violence | This refers to any increase in the intensity of violence over the past 6 months—including stalking. |
| Coercive control | This refers to a pattern of repeated behaviours to dominate and control one's partner that may underpin other risk factors and may change or escalate in interaction with other risk factors. |

[47] DCYJMA 2022, *Child Safety Practice Manual—Risk assessment,* https://cspm.csyw.qld.gov.au/practice-kits/domestic-and-family-violence/risk-assessment/seeing-and-understanding/risk-assessment#Lethality_indicators

| High-risk factors for lethality and serious injury | |
|---|---|
| **Lethality indicators** | **Considerations** |
| Injuries | Consider if the woman, child or someone close to the woman has been hospitalised because of the violence in the last 12 months. |
| Pregnancy | Domestic violence often starts or becomes worse during pregnancy. If a victim reports violence during pregnancy, there is a high risk that the violence will continue in future. |
| Threats to children | The father may use threats to harm the children as a way of maintaining control. If he is no longer living in the family home, check if he complies with contact arrangements. For example, is he returning children late from contact or refusing to return them? See the Post-separation power and control wheel for further information about the ways contact with children can be used to harass and intimidate their mother. |
| **Other general risk factors** | |
| Hostage taking | This is a sign of the father attempting to maintain a high level of control over the victim. It may also be a sign that they are losing control. |
| Acute depression and serious mental illness | Being mentally ill does not in itself mean that a person is likely to be violent, but in murder-suicide situations, the perpetrator often has a co-existing mental illness (in particular, depression). |
| Abuse or killing of pets | Research into family violence and animal abuse has found some men hurt or kill family pets to maintain control over the victim. Harm to animals correlates with a high risk of serious violence to the victim as well as an increased level of risk to children. |
| Extreme dependence on the victim | If a father using violence cannot accept the possibility of living without the woman, he may feel he is losing control if she attempts to leave the relationship or make other changes. He may try to regain control by seriously harming or killing her. This is often expressed as ‘I can’t live without you’ or ‘If I can’t have you, no one else will.’ |
| Previous history of severe violence | Men’s use of violence tends to escalate both in severity and frequency over time. |
| Alcohol and other drug use | Although alcohol and other drugs do not cause people to become violent, they can lower inhibitions and impair judgement. |
| Repeated calls to police | Calling police is usually the last course of action taken by mothers. Repeated calls to police usually mean the woman is extremely fearful for her safety. |
| Getting away with abuse | If the father has previously breached a domestic violence order (DVO) without any consequences, he may have less regard for the law and legal consequences. |

| High-risk factors for lethality and serious injury | |
|---|---|
| **Lethality indicators** | **Considerations** |
| Unemployment | If a violent man has recently lost his job, the victim may be at higher risk. |

# Attachments

ATTACHMENT A—LITERATURE REVIEW

## Table of contents

**Background** ............ **36**

**1. The effectiveness of DFV perpetrator interventions, particularly those aimed at fathers who are perpetrators of violence** ............ **36**

EFFECTIVENESS OF MEN’S BEHAVIOUR CHANGE PROGRAMS ............ 37

**Barriers to behaviour change and the role of motivation** ............ 38

**Fathering in the context of DFV** ............ 39

FATHERING PROGRAMS FOR MEN WHO USE DFV ............ 39

**Effectiveness of fathering programs for men who use DFV – individual programs** ............ 39

HEALING PROGRAMS FOR ABORIGINAL MEN ............ 42

**2. Enablers and barriers for engaging parents as victims or perpetrators in domestic and family violence services or interventions, including where other parental risk factors are present** ............ **43**

INDIVIDUAL LEVEL FACTORS ............ 43

SERVICE AND SYSTEMS-LEVEL FACTORS ............ 45

**Awareness of systems abuse** ............ 48

HOLISTIC AND TRAUMA-INFORMED RESPONSES ............ 48

CULTURALLY APPROPRIATE ENGAGEMENT ............ 49

**3. domestic and family violence in the context of other common parental risk factors among families in contact with the child protection system** ............ **52**

SERVICE RESPONSES TO COMPLEX CIRCUMSTANCES ............ 53

**4. Enablers and barriers for effective interagency collaboration and communication to address domestic and family violence within vulnerable families** ............ **55**

PRACTICAL BARRIERS AND POTENTIAL FACILITATORS TO COLLABORATION ............ 56

**References** ............ **60**

## Background

It is widely established that children's exposure to domestic and family violence (DFV) - including behaviours such as coercive control - can have significant and damaging short- and long-term impacts on their development, health, behaviour, and psychological and emotional wellbeing.[1] Within child protection involved families, DFV is disproportionately present, and research increasingly demonstrates that children's safety and DFV cannot be considered independently.[2] While anybody can be a victim of DFV, evidence clearly indicates that DFV is a gendered form of violence, with men making up the majority of perpetrators and women and children identified more frequently as the victims.[3] For the purposes of this review, DFV is framed as men using violence against women and their children.

System responses to DFV have historically centred around encouraging (or requiring) women to end violent relationships, with an assumption that ending a relationship will translate to improved safety for women and their children.[4] Research disproves this assumption, repeatedly showing that separation and post-separation represent periods of heightened risk for harm, up to and including lethal violence.[5] Basing system responses around gendered assumptions about parenting[6] and a primary caregiver (the mother) who is 'responsible' for ending the violence by ending a relationship has been heavily criticised as victim-blaming.[7] This approach also fails to reflect the reality of legal systems that support (or mandate) ongoing contact between a child and their parent, even in instances where that parent may have perpetrated DFV.[8] Abuse can continue throughout and beyond the process of separation, with children often being used as an extended tool of power and control by the abuser.[9] In addition, it is well documented that many abusive fathers continue to live with their partner and children.[10]

To reflect families' experiences, systems responses should strive to make contact safe for both the non-offending parent (usually the mother) and their children, and better recognise the impacts that DFV has on children.[11] Achieving this requires emphasis to be placed on holistic interventions, fathers' responsibility for not exposing children to DFV, and involving abusive fathers in service responses.[12] This calls for a move away from holding the primary victim accountable for children's exposure to DFV - which can render the perpetrator 'invisible' to systems[13] - and towards placing greater accountability on perpetrators of abuse.[14] Accountability extends beyond men's use of DFV against (ex)partners, to consideration about the capacity of men who use DFV to parent/co-parent effectively; men who perpetrate DFV against (ex)partners frequently have compromised parenting skills and pose high levels of risk to children.[15] This shift in thinking has driven the development of practice models such as Safe and Together, which seeks to increase men's 'visibility' to systems and is built on principles of child safety and partnership with the non-offending parent, and perpetrator accountability and intervention.[16]

Perpetrator behavioural change is a key element of any accountability and intervention framework. Men who use DFV are increasingly required or encouraged to participate in behaviour change interventions, as part of either a legal[17] (court-mandated participation) or social (voluntary participation)[18] accountability framework.

## 1. The effectiveness of DFV perpetrator interventions, particularly those aimed at fathers who are perpetrators of violence

Broadly, there are three types of interventions aimed at men who perpetrate DFV: men's behaviour change programs (MBCPs), fathering programs for men who perpetrate DFV, and healing programs for Aboriginal men.[19] Each intervention is considered below.

Men's behaviour change programs (MBCPs) aim to hold DFV perpetrators accountable for their use of violence, and change their harmful behaviours to build healthy relationships and enhance women's and children's safety.[20] Other aims include providing a mechanism of monitoring participants' use of violence and the risks they present to their (ex)partners and children.[21] MBCPs typically run over a period of three to six months, and usually comprise initial assessment, followed by weekly group sessions. They may include a mixture of mandated and voluntary

participants, as well as men who are, and are not, fathers. MBCPs differ in the extent to which they offer (or have the capacity to offer) individual sessions and case management[22] and have been criticised for adopting a 'one size fits all' approach that does not take into account individual characteristics, histories, and needs.[23]

MBCPs are informed by a range of different theoretical and empirical perspectives. For example, many MBCPs in Australia draw heavily on the Duluth model.[24] This model operates from a feminist approach, emphasising concepts such as patriarchal power and control. Other MBCPs adopt psychological concepts such as cognitive behaviour therapy or 'motivational interviewing'.[25] Some MBCPs focus on anger and emotional regulation, or on trauma-informed practice that explores underlying factors for DFV, while others use approaches such as strengths-based practice, family therapy, or narrative therapy.[26] Increasingly, MBCPs incorporate elements from multiple different practice frameworks (for example, in Queensland, the Men Choosing Change program draws on several different theoretical and practical approaches).[27] How much emphasis each specific approach receives within an overall program varies considerably, and exact program content is not routinely made available within published program evaluations or research studies.[28]

MBCPs typically focus on improving women's safety, with an implicit assumption that a reduction in violence will also result in benefits for children.[29] MBCPs generally offer advocacy and safety support for adult and (usually indirectly) child victims of DFV. This can take forms such as information provision, referrals, safety planning, counselling and/or case management. Again, this varies considerably across different MBCPs. MBCPs ideally operate within the context of integrated systems responses, however the extent to which this occurs in practice varies greatly.

## EFFECTIVENESS OF MEN'S BEHAVIOUR CHANGE PROGRAMS

There have been numerous evaluations of MBCPs.[30] Many evaluations have been process or output orientated, [31] focusing on (for example) whether a program aligns with relevant guidelines, or the percentage of participants completing the program.[32] Regarding outcomes, no clear picture emerges of whether MBCPs are effective in changing behaviour.[33] Reported results vary greatly, likely due to the considerable diversity between MBCPs in conditions of participation (mandatory or voluntary; participants in mandated programs have been found to have more complex circumstances and greater resistance to change than participants in voluntary programs[34]), program content, duration and intensity, participant characteristics, referral sources, delivery mode, and facilitator qualifications and experience.

Australian evaluations of MBCPs often use inadequate measures of change, and provide little insight into what works, and for whom.[35] Studies tend to be methodologically limited (for example, due to small sample sizes, and/or definitional inconsistencies about what constitutes 'success'). Evaluations that use official data (such as police records) cannot be directly compared with studies that rely on self-reports; official records are likely to underestimate recidivism,[36] while self-reports may vary in accuracy depending on whether they are made by the perpetrator or the victim/s. Not all studies gather data from (ex)partners and few evaluations have directly engaged with children and/or incorporated child wellbeing measures.[37] Few studies conduct follow-ups over time, which limits knowledge about long-term risks/impacts for women and their children.[38] Where follow-ups have occurred, evidence provides limited support for MBCPs' ability to create sustained improvements.

A relatively consistent finding is that Duluth-style programs tend to be the least effective.[39] Programs of more than four months' duration and 'high intensity' programs that require more frequent attendance tend to be associated with more positive outcomes, however longer/intense programs can also be associated with higher attrition rates due to the greater level of 'demand' they place on participants. More positive findings emerge from MBCPs that are based around holistic intervention, and that include elements such as motivational approaches, treatment for substance use, and treatment for comorbid mental illness.[40] A small body of evidence suggests that programs may be enhanced by co-location with other services (e.g., for substance use issues).[41] However, the evidence base for those types of interventions remains small. There are very few evaluations of whether programs specifically aimed

at addressing DFV are any more or less effective than programs that address issues associated with DFV, such as substance use.

There is a particular lack of evidence around whether MBCP outcomes vary depending on a participant's cultural background. For example, there has been almost no research into the efficacy of MBCPs among Aboriginal and Torres Strait Islander DFV perpetrators,[42] and a lack of standardised measures heightens the difficulty of comparing across different studies.[43] Emerging evidence, including from Queensland, strongly suggests that 'mainstream' MBCPs may be inappropriate for participants from culturally and linguistically diverse backgrounds.[44]

### Barriers to behaviour change and the role of motivation

Barriers to men changing their behaviour include men not perceiving their behaviour as problematic, victim-blaming/viewing their (ex)partner as the problem, not perceiving the impacts of their behaviour on others (including their children), believing themselves to be the victim, and not perceiving negative consequences (legal or social) associated with their behaviour.[45] Perpetrators who are repeat offenders, or who have attended MBCPs in the past, may be least likely to change their behaviour.[46] Men's 'readiness' or motivation to change appears to be crucial to MBCP effectiveness.[47] A lack of motivation to change, particularly in court-mandated MBCP cohorts,[48] is a key challenge to engaging men in MBCPs.[49] Motivation to change may also predict whether behavioural change is sustained over time.[50] The role of motivation may be especially noticeable among the most 'high risk' perpetrators; for example, Crane[51] found that readiness to change was lowest among men who believed that they were the victims, rather than the perpetrators, of DFV.

Although not all men who perpetrate DFV are fathers, many are. Fatherhood may be a significant motivator for encouraging men to accept accountability for their actions[52] and change their behaviour.[53] Australian research suggests that even when men come to recognise the impacts of their DFV on children, they typically fail to make the connection that the involvement of statutory child protection services in their lives was a direct consequence of their abusive behaviour.[54] Nevertheless, many fathers who perpetrate DFV express a wish to have a relationship with their children and be 'good' fathers.[55] Fathers' motivation to attend and succeed in MBCPs often centres around improving their parenting and relationships with their children.[56] While research on father engagement is relatively scarce,[57] evidence suggests that tapping into a man's desire to be a better father may be an effective means through which to address his use of DFV.[58]

A small body of Australian research examines how men who perpetrate DFV view their role as fathers and their relationship with their children, producing findings that are consistent with international research. For example, Broady and Grey,[59] using interviews with 21 men in a MBCP in New South Wales, found that the main theme underpinning all fathers' discussions of children was that love for their children served as a motivation to stop using DFV. Men demonstrated a wide range of attitudes towards their (ex)partners, but unanimously reported a desire to maintain meaningful relationships with their children.

Meyer[60] interviewed 18 fathers participating in a court-mandated MBCP in Queensland. Accountability as a father did not form a specific focus of the program content and none of the men had completed a parenting-focused intervention program. Fathers often saw themselves as protectors, and most expressed a strong desire to be a significant part of their children's lives. Few fathers accepted that court orders prevented them from spending time with their children. Fathers expressed concerns about the other parent exposing their children to harm. This reflects victim-blaming attitudes and a deflection of their own accountability,[61] however it also highlights the possible motivating role of the father-child relationship in achieving change.[62]

While children may be used in discussions as a motivator for change, few MBCPs address fathering practices directly, or seek to change DFV behaviours that can impact on the father-child relationship and undermine the mother's parenting ability. Reducing DFV and improving women's safety are likely to correlate with increased safety for children. Interventions that focus on parenting relationships as well as partner relationships are likely to

promote better outcomes for families, including children.[63] In some countries, peak bodies[64] now stipulate that MBCP providers must include a focus on fathering. In Australia, the Experts Advisory Committee on Perpetrator Interventions in Victoria recommended the inclusion of fathering content within MBCPs.[65] However, there are no clear requirements as to how this should occur, and the extent to which such recommendations translate into attention to fathering in practice is unclear.

### Fathering in the context of DFV

Many fathers who perpetrate DFV demonstrate poor parenting skills due to their lack of parenting experience, over-controlling behaviour, self-centred attitudes, and sense of entitlement.[66] They may use harmful parenting practices, including physically punitive and authoritarian parenting styles[67] which place children at risk of serious harm.[68] They may have poor understandings of child development, and inappropriate expectations of their children.[69] They are typically unaware of the impacts of their use of DFV on their child and their relationship with their child, and do not recognise the negative impacts on children of behaviours such as undermining the child's mother, or the relationship between their use of DFV and other factors that may impact on the child's wellbeing (such as the mother's parenting capacity, mental health, or substance use).[70]

## FATHERING PROGRAMS FOR MEN WHO USE DFV

While using fathering as a motivational tool has a long history in generalised parenting programs (which may include participants who perpetrate DFV, but are not specifically aimed at that group), there is growing interest in fathering programs that focus on fathers as perpetrators of DFV. These programs have varying objectives (e.g., increasing accountability while decreasing violence, increasing awareness about positive fathering, or fostering positive father–child relationships) and are underpinned by a range of theoretical frameworks (e.g., feminism, restorative justice, family system theory, motivational interviewing and psychoeducation).[71]

Incorporating fathering issues into traditional MBCPs is challenging, for a range of practical and philosophical reasons, which has led to the relatively recent development of standalone fathering programs for men who use DFV.[72] These programs are typically voluntary. They focus on three key areas of education: the impact of DFV on children's development and wellbeing, the impact of DFV on forming and maintaining father-child relationships, and the impact of repercussions for abusive behaviour (such as incarceration or non-contact orders) on fathers' ability to form and maintain meaningful relationships with their children.

### Effectiveness of fathering programs for men who use DFV – individual programs

Many standalone programs are based around the 'Caring Dads' (CD) model, which originated in Canada. CD is aimed at men who have been abusive towards their children, their children's mother, or both. It is voluntary, and fathers may self-refer or be referred from a wide range of services including child protection, traditional MBCPs, or police. Participants attend a two hour group session – ideally facilitated by one male and one female worker - every week for 17 weeks.[73] CD consists of four modules, which aim to (1) engage men in examining their fathering, (2) teach awareness and application of child-centred parenting, (3) encourage awareness of and responsibility for abusive fathering behaviours and (4) address rebuilding trust with children and plans for the future.[74] CD uses components of traditional MBCPs, motivational interviewing and child development, but remains focused on children's safety and wellbeing and the link this has with the safety and wellbeing of the mother. Facilitators aim to contact mothers three times during the program to provide information and referrals to support services, and ensure that mothers and children are safe.[75]

International evaluations of CD have generally found mixed evidence for men's behaviour change.[76] When changes have been observed, those generally relate to modest improvements in co-parenting and less dysfunctional parenting/more child-centred parenting practices by fathers. For example, two UK studies suggested that fathers showed greater awareness of the impacts of DFV on children post-program. Two UK studies included assessment of

child behavioural difficulties, and did not find evidence for significant improvements. Although some evaluations have found reductions in men's use of DFV, those changes are typically small. One UK study found evidence that changes may persist over time. It appears that program impacts may differ between different groups of men; men who remain partnered typically show more change (mainly in co-parenting), whereas men no longer in a relationship with the mother of their children appear more resistant to change.

Early Canadian evaluations of CD,[77] based on small numbers of men, found that fathers' self-reported levels of hostility, denigration, and rejection of their child and their level of angry arousal to child and family situations decreased significantly over the course of intervention. Post-CD there were small but statistically significant improvements for some parenting measures, including hostility. There were statistically significant improvements in men's co-parenting scores. For generalised anger, pre- and post-CD differences were not significant. Reductions in self-reported abuse of children's mothers did not reach statistical significance. The studies did not gather information from men's (ex)partners.

McConnell and colleagues[78] considered five CD sites across England, Northern Ireland and Wales. Information was gathered from current and former partners, and children where possible. There were significant improvements in fathers' reported parenting stress, parent-child dysfunctional interaction, and perceptions of their child being difficult. Data from fathers approximately six months after the program suggested that improvements were maintained. The majority of children described fathers demonstrating more child-centred behaviour, and improvements in the way their father communicated with them. While children's reports of rejecting behaviour from their father appeared to reduce, the change was not statistically significant. Although the average score for children's behavioural difficulties reduced, none of the changes were large or statistically significant.

Fathers and partners both reported reductions in DFV incidents, including controlling behaviour. Partners reported that denials of abuse, and abuse using children, declined more than other forms of abusive behaviours. Partners continued to report incidents of abuse after the program, although to a lesser extent than pre-program. Partners described fathers who were more cooperative co-parents and recognised the impact that DFV can have on children.

McCracken and Deave[79] evaluated a Welsh version of CD. Fathers reported declines in parenting stress and dysfunctional parent-child interactions at the end of the program. Modest improvements were found in fathers' attitudes towards parenting and awareness of the impacts of their behaviours on children, however few changes were observed in attitudes and hostility towards their (ex)partners. The main mechanism and motivation for change was fathers' ability to identify the impact of their behaviour on their children. Very few (ex)partners provided information about men's behaviour and their safety. The evaluation also found a small post-program increase in the number of men who were more likely to give socially desirable responses. The authors highlight that the risk levels men present should be closely monitored throughout the program, using information from sources such as police, probation, social services and court services.

Hood and others'[80] evaluation of CD in London suggested that fathers shifted towards more appropriate attitudes and parenting practices during the program, however quantitative data showed no significant changes in father involvement, parenting alliance, parenting practices, or children's psychological behaviour. Some fathers appeared to adopt concepts about child-centred parenting in order to criticise mothers. Child services workers' assessment of risk to children and (ex)partners remained unchanged for over half of the cases. While workers' concerns about domestic and family violence tended to improve at the end of the program, that was not sustained over time. Lower levels of concern were reported about the father-child relationship, however (due in part to sample attrition) it is unclear whether those changes were sustained. Collateral information from mothers was not reported.

In Germany, Liel and colleagues[81] evaluated fathers who participated in CD. They also gathered information from mothers. Pre- and post-intervention measures found improvements in levels of fathers' aggression and parenting behaviours, as well as mothers' views about co-parenting and fathers' behaviour toward them. Improvements in co-

parenting from the mother's perspective may have been due to mothers who were still living with the father taking part in the evaluation more frequently than mothers who no longer lived with the father. For parents living apart, co-parenting continued to be characterised by more conflict than couples who still lived together.

There have been two Australian evaluations of CD. Consistent with international evaluations, Australian studies have found limited evidence for men's behavioural change as a result of the program. Both studies collected data from fathers and mothers, and found small (typically not statistically significant) improvements in fathers' co-parenting, and slight (again, typically not significant) changes in reported use of domestic and family violence. Similar to international findings, it appears that changes were mainly observed among men who remained partnered, and there was limited evidence that changes persisted over time. Children's perspectives/child wellbeing measures did not form part of either evaluation.

In Victoria, Diemer and colleagues[82] evaluated a CD trial at three sites (two metropolitan, one rural). Information was gathered pre-, post-, and 12 months after the program. Fathers and mothers reported improved fathering practices post-program, although changes typically did not reach statistical significance. Sustained changes were not apparent for the majority of fathers, and fathers who were no longer in a relationship with the mother were less likely to change.

Fathers believed they were less hostile to the mother following CD whereas mothers did not report significant change. About half of fathers, regardless of relationship status, continued to speak negatively of mothers, deny their use of violence, and blame the mothers for a difficult relationship and/or poor parenting. At the 12-month follow-up period, a substantial number of women continued to report domestic and family violence (however, very few women participated in the follow-up interviews). Mothers typically felt safer while men were in the program.

In general, fathers who participated in additional interventions (e.g., individual counselling, MBCPs, or repeating CD) showed the most change. Fathers who were in a crisis stage or caught up in court processes often found it difficult to focus productively on the program content, and the authors suggest that for those men there could be benefit in spending more time in program preparation, and/or intensive domestic and family violence-informed counselling. The evaluation identified that the largest limitation to sustaining long-term behavioural change is the lack of system-wide practices observing men in their fathering role and holding them to account for their behaviour after they leave the program.

In Queensland, Hine and colleagues[83] evaluated CD in two trial regions. Around two thirds of the sample were parents who remained together. Indigenous CD participants were less likely than other participants to consent to evaluation participation. When asked why they agreed to participate in CD, the top two responses by fathers were that they (a) wanted (or were mandated) to satisfy involved agencies and (b) desired to improve their parenting techniques and skills. Other common responses included improving their behaviours and wanting more access to their children.

There was a small, non-significant improvement in mothers' reported feelings of safety.[84] Mothers reported experiencing less harassment and abuse over time. For sexual and physical violence (which were reported to be low to start with), there was a small improvement, although this was not statistically significant. Mothers' perceptions of the level of respectful communication in their relationship showed slight, but not significant, improvement.

Both parents reported less co-parenting conflict at the end of the program however the change was not significant. Separated mothers may have experienced an increase in problematic shared parenting behaviours (e.g., fathers undermining or criticising mothers in front of their children) during and post-program participation.[85] The small sample size did not allow for analysis of specific subgroups, including Aboriginal and Torres Strait Islander participants.

## HEALING PROGRAMS FOR ABORIGINAL MEN

Healing programs for Aboriginal men[86] focus on a range of issues, including the use of domestic and family violence. They use cultural, spiritual, educational and therapeutic healing activities, and consider men's experiences and the impacts of colonisation and intergenerational trauma.[87] They work from a culturally appropriate perspective that emphasises all aspects of an individual's mental, physical, emotional, and spiritual health.[88] Their goal is to create behavioural change and healing in a non-shaming environment, to strengthen men's identity, and to support men to become leaders, mentors, and role models in their communities.[89]

In jurisdictions such as North America and New Zealand, there are numerous culturally informed programs aimed at addressing domestic and family violence from both victim and perpetrator perspectives.[90] However, a majority of programs work with women and their children,[91] and in many instances violence reduction initiatives form part of broader Indigenous-designed and delivered programs and services to improve healing, health and wellness.[92] Different systems of governance, and different formalised relationships between mainstream and Indigenous communities and service providers in different jurisdictions, make it difficult to extrapolate from those jurisdictions to Australian contexts.

In Australia, many studies have examined what Aboriginal and Torres Strait Islander communities believe will work to address domestic and family violence, or what features may make a men's healing program appropriate for participants and communities.[93] However, there has been relatively little outcome evaluation of men's healing programs in the domestic and family violence context.[94]

A commissioned evaluation of Dardi Munwurro healing programs in Victoria suggested that men self-reported increased feelings of improved relationships, taking responsibility for their behaviour, and connections to community. Men also self-reported reductions in substance use (from around 80% pre-program to 34% post-program), improvements in their ability to manage their emotions, understand the impact that violence has on family and community, and accept responsibility for violent actions, and reduction in the number of episodes of domestic and family violence requiring police involvement. Information was not obtained from (ex)partners or children. Exact sample sizes of adult men participating in the range of different programs were not consistently reported.

In the Northern Territory, initial evaluation was undertaken on the Our Men Our Healing program,[95] which ran across three locations. Findings suggested that participating men perceived improvements in their relationships, an increase in understanding ways of managing relationships in a safe and supportive way, and that families perceived an increase in feelings of safety and support. Participant numbers and results varied considerably across the three sites.

The limited availability of evaluation data, as well as the use of different research methods, measurement tools, and definitions of change, and frequent use of qualitative, rather than quantitative, information make it challenging to directly compare outcomes across Aboriginal healing programs and mainstream MBCPs or fathering programs. Regardless of these limitations, it is clear that to be effective at engaging with participants – which is a necessary first step towards effective outcomes - programs must be holistic in focus. They must be culturally competent and sensitive to historical context, trauma-informed, and be co-designed with communities (including the target group for the intervention) as well as (ideally) community owned and led, and incorporate inter-sectoral linkages and wraparound support models.[96]

### *Summary*

- *Fatherhood can be a significant motivator for encouraging men to accept accountability for their actions and facilitate behaviour change, however most men's behaviour change programs (MBCPs) do not directly address fathering practices or seek to change domestic and family violence behaviours that can impact on*

*the father-child relationship and undermine mothers' parenting ability. A general focus on parenting relationships as well as partner relationships is seen to promote better outcomes for families, including children.*

- *While fathering programs for men who use domestic and family violence appear to show promise for encouraging change in fathers' parenting/co-parenting, there is limited evidence as to whether programs affect domestic and family violence behaviours or child outcomes – especially over the longer term.*
- *There is little incorporation of children's perspectives into existing evaluations, and limited evidence of improvements in child wellbeing following fathers' program participation. Further, many evaluations are subject to limitations, such as small sample sizes, different definitions and methodological approaches that influence results. Positive findings may have arisen due to differences in motivation or other factors between men who do and do not engage with or complete programs.*[97]
- *Similarly, there is limited evidence on the use of healing programs to work with Aboriginal and Torres Strait Islander men who perpetrate domestic and family violence. To support engagement, programs must be holistic, culturally competent and sensitive to historical context.*

## 2. Enablers and barriers for engaging parents as victims or perpetrators in domestic and family violence services or interventions, including where other parental risk factors are present

Families with high/complex needs – and where domestic and family violence and child protection concerns frequently co-occur – have low levels of engagement with services.[98] While there are many different theoretical conceptualisations of 'engagement,'[99] it is used here as a general term that includes 'getting' individuals to have initial contact with services, 'keeping' individuals in contact with services, and working with individuals over a period of time.[100] The following sections incorporate evidence about barriers and enablers to engagement from a wide range of different service and intervention contexts that intersect with domestic and family violence. Emphasis is placed on child protection, however consideration is given to healthcare, policing, and family support services more generally, in recognition of their contact with families experiencing domestic and family violence.

### INDIVIDUAL LEVEL FACTORS

In many instances, barriers and enablers to engagement are two sides of the same coin. For example, both victims and perpetrators of domestic and family violence – including within child protection contexts in Queensland - consistently report that services' willingness to listen and workers' attitudes towards them can be a barrier or an enabler to engagement.[101] In addition to listening and attitudes, Australian and international research across a range of different settings (e.g., child protection, domestic and family violence services, healthcare, policing) consistently finds similar key barriers to service engagement at the individual level, particularly for women/mothers experiencing domestic and family violence.[102]

These include:

- stigma, guilt, and shame/self-blame
- lack of trust in services
- fear of not being believed
- fear of punitive consequences upon seeking help for domestic and family violence, such as fear of child removal due to mandatory reporting

- past negative experiences with services (e.g., not receiving help, nothing changing, or being viewed as a perpetrator rather than a victim of violence)
- lack of knowledge of available services
- perceptions that services do not understand domestic and family violence
- confidentiality concerns/fear of a partner finding out
- loyalty to a partner/wanting to avoid consequences to a partner
- fear of a relationship ending/impacts on other circumstances such as housing and finances
- lack of access to practical resources such as transport/childcare
- perceived social acceptance of violence
- mental health and/or substance use issues (and/or lack of support for those)
- some studies have identified children's ongoing contact with the abusive parent as a barrier to engagement, particularly engagement with children's support services in instances of co-parenting.[103]

Lack of trust in, and fear of, mainstream domestic and family violence and child protection services may be especially prominent among Aboriginal and Torres Strait Islander mothers, due to intergenerational trauma, the lasting impacts of colonisation, and historic child removal practices. This can create additional barriers to help-seeking for mothers who fear the removal of their children when disclosing domestic and family violence.[104]

Research reveals a consistent set of facilitators to initial and ongoing engagement,[105] including:

- strong referral pathways
- clear information about programs
- proactive initial outreach by the service
- flexibility in service delivery
- consistent and direct communication between sessions
- perceived appropriateness of the therapeutic approach
- respect and trust for the service and its workers, to build a therapeutic relationship
- culturally- and trauma-informed practices and culturally appropriate service provision.

It is widely recognised that in child protection involved families, fathers generally have low levels of service engagement.[106] Barriers such as fathers' 'invisibility' to services and fathers' denial of their own responsibility, as well as facilitators such as wanting to improve their relationship with their children, have already been discussed in Section 1.

Some barriers to engagement are similar between mothers and fathers, such as negative past experiences with services,[107] stigma/shame, and practical factors, such as timing (for fathers who work), venue location, proximity to public transport, service costs, and the provision of child care.[108] It is well established that men's psychosocial characteristics - such as substance use – limit their ability to effectively engage in services addressing their use of domestic and family violence.[109] Fathers may also be reluctant to engage with services for a range of other reasons,[110] including:

- fear that they cannot be good fathers for their children
- fear that involvement with the child protection system will exacerbate their problems with the criminal justice system

- fear that relationships with current partners not related to the child would be affected
- fear of consequences of disclosure, such as losing custody of children
- lack of trust in services' ability to address domestic and family violence
- a perception that 'the system' is not there to help them (this is particularly prominent for fathers with complex needs[111]).

Facilitators of engagement[112] can include:

- experiencing social and/or legal consequences of their domestic and family violence behaviours
- feeling listened to by services
- offers by services of emotional and practical support for relationship and other problems.

Men's partners can act as gatekeepers facilitating or inhibiting their engagement with programs.[113] In the context of domestic and family violence, this may intersect with women's fear that involvement with services may lead to outcomes such as child protection involvement due to mandatory reporting.

Psychological accessibility has been highlighted. This refers to individuals' perceptions of the service delivery environment, acknowledging that social and cultural attitudes may inhibit or facilitate engagement. Psychological accessibility may inhibit men's engagement with 'stigmatised' services, such as domestic and family violence services.[114] Weeks[115] suggests that the key to creating psychologically accessible services, and 'getting' fathers, is the provision of a non-stigmatising entry point. For example, a program to 'strengthen fatherhood' may be more psychologically accessible than a program to 'stop violence against women'. Service provision models matter: men/fathers may perceive services as only welcoming women/mothers and/or being antagonistic towards men/fathers (for example, by operating from strongly feminist principles).[116]

### SERVICE AND SYSTEMS-LEVEL FACTORS

Different services that come into contact with victims and perpetrators of domestic and family violence often report very similar experiences[117] about why they do not engage with those individuals, such as:

- inadequate training about domestic and family violence/ what to do if a disclosure of domestic and family violence occurs
- lack of confidence responding to domestic and family violence situations
- lack of time/time pressures
- lack of knowledge about making referrals/lack of referral 'pathways'
- negative attitudes towards victims/victim-blaming
- not knowing how to talk to children who are exposed to domestic and family violence.[118]

Lack of worker training, knowledge, and comfort in working with complexity can intersect with individual-level barriers to engagement. For example, in a child protection context, parents have reported higher levels of dissatisfaction and lower likelihood of meaningfully engaging with workers who they perceived as unqualified or incompetent. This includes workers who are perceived to be ignorant about the dynamics of relevant issues, including domestic and family violence, poverty, cultural differences, mental health and disability, or who were reported to have 'textbook understanding' but no real world knowledge. Incompetence also referred to workers who did not follow policies or procedures, were coercive, or who retaliated when parents did not cooperate.[119]

Service perceptions about men/fathers represent a key barrier to engagement. Within a general systems context (not specifically focusing on domestic and family violence), Ghate and colleagues[120] showed that referral policies and systems filter men's access to services. For example, family centres attribute the absence of fathers to the fact

that mothers are the referred clients with whom the centres develop a relationship.[121] Similarly, Ferguson and Gates[122] found policy directives identifying mothers as the primary clients of the Family Nurse Partnership program in England led some staff to exclude fathers. Ghate and colleagues[123] contend that 'feminised environments' inhibit father engagement by only allowing men to engage with family services on women's terms or by becoming 'pseudo-women'. Likewise, mother-centric program content may not be appropriate for fathers.[124]

Perceptions about fathers may have particular impact within child protection contexts. For example, in a UK based evaluation of two multi-agency projects providing holistic, early intervention to domestic and family violence families, Donovan and Griffiths[125] found four main reasons why services did not engage with fathers:

- work with perpetrators was not within the remit of agencies
- when it was part of their remit, it was through a criminal justice lens
- agencies such as children's services claimed to work with families but in practice this meant mothers and children only
- female practitioners felt unsafe about engaging with perpetrators, especially in a domestic setting.

A perception that men pose a risk to children and that fathers may be intimidating, intoxicated, and/or abusive to workers, can lead child protection caseworkers to be reluctant to confront or engage with them or to purposefully avoid them for fear of violent reactions.[126] Those experiences can create a perception of fathers as dangerous non-nurturers[127] and negate the prospect of engagement.[128]

Some studies find that case workers frequently deem fathers irrelevant.[129] For instance, in Baynes and Holland's[130] UK study of 40 child protection case files, over a third of fathers had no contact with a social worker prior to the first child protection meeting. In Roskill's[131] file audit of UK cases involving men using domestic and family violence, the father was neither seen nor contacted in around a third of the cases. Maxwell[132] argues that to protect and support children, practitioners need to proactively assess and engage with all significant men in a child's life.

Using survey data from 100 Australian social workers, Mandara and colleagues[133] note that social workers who are first responders to domestic and family violence can lack confidence in engaging with men who use violence and working with women and children who experience domestic and family violence. Most study participants recognised signs of domestic and family violence, but responses were mainly focused on referring women to practical or accommodation support, and children to psychological support. Responding to perpetrators was rarely mentioned. The authors suggest that continuing professional development is required so that practitioners can maintain, improve, and broaden their knowledge and skills as first responders and enhance opportunities for engagement and intervention.

Barriers to service engagement with fathers who perpetrate domestic and family violence may include gendered practices such as recording greater information about the mother, regardless of who is responsible for abusing the child or who the child lives with.[134] For example, using case files gathered from across five Australian states, Humphreys, Healey and Mandel[135] used the Safe and Together framework to assess the quality of child protection service practices. They found a number of examples of poor engagement and intervention with perpetrators of domestic and family violence and missed opportunities to partner with the non-offending parent, and cite gendered, perpetrator-invisible practices such as a mother being referred to as a 'good' protective mother for calling the police but a 'bad' protective mother when she stopped calling the police because that no longer proved effective in responding to domestic and family violence. Examining Queensland child protection legal information, De Simone and Heward-Belle[136] observe that lawyers and child protection workers adopt gendered representations of domestic and family violence by collecting limited evidence about fathers' perpetration patterns and fathering practices.

To overcome barriers to services’ engagement with fathers who perpetrate domestic and family violence, early identification and involvement of fathers is a crucial first step. This may include measures such as fostering an expectation that service providers (particularly, child protection workers) are expected to proactively engage with fathers and that it is a part of their role to work to include fathers and improve fathers’ understanding that they are expected to engage with those services.[137]

### Awareness of systems abuse

Service engagement by domestic and family violence perpetrators is generally viewed as positive, however the risk of systems abuse - manipulation of legal, administrative and/or welfare systems in order to exert control over, threaten, or harass a current or former partner[138]- must be recognised. Systems abuse can include behaviours such as the perpetrator of domestic and family violence portraying themselves as the victim in order to have action taken against the genuine victim, and/or making allegations to relevant authorities that the victim of domestic and family violence has perpetrated violence in front of their child.[139] Family law systems, including child protection services, are at particular likelihood of being misused; this has been observed in Queensland.[140]

domestic and family violence perpetrators can use threats of systems involvement and punitive service system responses as part of their controlling behaviours. This can lead to victims not engaging with services out of fear that perpetrators will follow through on threats. Mothers have used descriptions such as: '[my husband] would find out and punish us as promised over the years, and he will take [my child]…and I'll never see her again.'[141] Service involvement in the context of systems abuse can lead to development or exacerbation of victims' self-blame, shame, and guilt,[142] as well as mental health and/or substance use issues.[143] These issues in turn can increase the likelihood that perpetrators will avoid accountability.[144]

Meyer's[145] interviews with 9 Aboriginal and Torres Strait Islander mothers in regional Queensland revealed how some perpetrators strategically used mothers' health needs as a weapon and tool of entrapment. Women described how choosing to take care of their own needs (e.g., mental health needs associated with the impact of ongoing trauma) was associated with being framed as a bad mother. Partners were documented as stating, for example, that a mother would be seen as unfit if she sought treatment, which reduced mothers' help-seeking due to fear of child removal. This highlights the importance of culturally informed understandings of how systems abuse can act as both an element of domestic and family violence and a barrier to engagement.

## HOLISTIC AND TRAUMA-INFORMED RESPONSES

Many families where domestic and family violence is present have complex circumstances marked by interconnected factors that underlie and sustain domestic and family violence, such as parents' adverse childhood experiences (ACEs) (including child abuse, neglect, and exposure to domestic and family violence in their family of origin), substance use, mental health issues, criminal justice system contact (non-domestic and family violence related), low levels of educational attainment, socioeconomic disadvantage, and unstable housing. For example, in Meyer's[146] sample of 18 Queensland fathers participating in a court-mandated MBCP, 14 fathers reported lifestyles marked by childhood abuse, substance use, inconsistent employment, low levels of education, and (non-domestic and family violence) criminal convictions. Eight fathers described highly volatile relationships, including alleged reciprocal violence, and drug and alcohol use by both victim and perpetrator.

The intergenerational nature of child maltreatment has long been recognised, however a growing body of research demonstrates that a history of ACEs not only predicts child maltreatment,[147] substance use and poor mental health outcomes among parents,[148] but also influences engagement of men who use domestic and family violence with both mental health treatment and MBCPs.[149] Engagement with services for both victims and perpetrators may be facilitated by a trauma-informed approach that understands and accepts that trauma histories can impact behaviour and functioning.[150] A trauma-informed approach includes creating safe physical and emotional environments for delivering an intervention, modelling healthy relationships, and working with other agencies to offer integrated support.[151]

Numerous studies, including in Australia, have identified that vulnerable parents with multiple life stressors have to overcome numerous obstacles and balance competing needs.[152] It is likely that at times, basic or 'survival' needs take priority over attendance at a service (particularly services which lack an immediate, tangible benefit).[153] For

families with complex circumstances, barriers can collectively become overwhelming, preventing parents from engaging with services.[154] Consequently, parents may be unable to effectively engage with interventions that place 'high demands' on them until their more basic needs have been met.

Research suggests that addressing clients' complex personal situations and how those intersect with service use is a necessary precursor to getting, keeping and engaging parents.[155] In contexts where multiple adversities are present, referrals to (for example) MBCPs are unlikely to be effective until and unless those other problems are addressed. Proactively recruiting specialist professionals to work with families to address the different components of their life circumstances and adopting a comprehensive and highly informed social work focus in responding to that family, can be crucial to facilitating families' engagement in interventions.

'Preparatory work' addressing parents' life circumstances can encourage engagement with interventions for domestic and family violence/parenting.[156] Preparatory work includes practices such as building rapport with both parents before making referrals, exploring what individuals see as their main needs and seeking to match service referrals to those, and finding and using services that are trusted by parents (if those exist). The latter point is especially relevant when working with families from culturally and linguistically diverse backgrounds.

Lack of worker training and knowledge can lead to responses that overlook the complex factors surrounding domestic and family violence and result in suboptimal or inappropriate referrals (including repeated referrals), which can in turn discourage parents' engagement.[157] Extensive and customised training for workers to recognise the complex circumstances that surround domestic and family violence appears beneficial, in order to more proficiently identify complex needs and engage families in services.[158]

In the Australian context, Humphreys, Healey and Mandel[159] acknowledge that it is challenging for statutory systems to provide appropriate and consistent domestic and family violence-related risk assessments.[160] They note that substance use and mental health concerns are extremely common in child protection cases, however analysis of case files showed that although it was common practice to list the co-occurrence of these factors, there was little evidence of how trauma, behavioural health, and substance use issues of the adult and child survivors were impacted by the perpetrator's use of domestic and family violence. There was practitioner focus on seeking feedback on referrals relating to adult victims (in relation to mental health, for example) but little evidence of such activity relating to referrals for men to other services (such as Aboriginal programs, MBCPs, and alcohol and other drugs services).

## CULTURALLY APPROPRIATE ENGAGEMENT

A large amount of Australian and international research demonstrates the need for cultural awareness in service delivery, to support engagement.[161] Sensitivity, flexibility and adaptability have been identified as crucial to services 'getting' and 'keeping' parents from culturally and linguistically diverse backgrounds.[162] While the cultural background of service providers may assist in initially 'getting' participants, it appears that interpersonal skills and cultural awareness, rather than cultural background in itself, are what facilitate ongoing engagement.[163] Worker training can impact on engagement. For example, Kaur[164] found that entry level child protection investigation officers working with culturally and linguistically diverse families in Queensland did not receive adequate training and resources, and lacked knowledge on how to deal with cross cultural issues when working with those families.

There are many shared barriers to service engagement between different cultural groups. However, barriers such as shame, living in communities where help-seeking from 'external' sources is discouraged, having extended family networks that perpetuate the use of domestic and family violence, as well as past inappropriate service responses causing mistrust and fear, are typically higher among Indigenous victims of domestic and family violence across Australian, Canadian, and New Zealand settings (and elsewhere).[165] Geographical factors such as living in regional areas rather than urban settings can represent a further barrier to service engagement by Indigenous domestic and

family violence victims (due to, for example, a lack of appropriate services, concerns about community perceptions/confidentiality, and/or services knowing the perpetrator socially).[166]

For Aboriginal and Torres Strait Islander families who experience domestic and family violence, engagement is likely to be facilitated by a framework that takes into account historical circumstances such as colonisation, dispossession, and a legacy of extreme socioeconomic disadvantage,[167] as well as addresses the practical implications of greater levels of exposure to challenges such as substance use, financial insecurity, and housing instability.[168] Aboriginal and Torres Strait Islander child protection workers in Queensland highlight that past welfare policies around child removal (and associated intergenerational trauma) and structural racism can impact uniquely on Aboriginal and Torres Strait Islander mothers' likelihood of engaging with services.[169] Similar observations have been made in New Zealand.[170] In addition, Queensland research in the child protection context has highlighted a need for culturally appropriate home visitation programs and parenting programs.[171]

### *Summary*

- *There are many individual-level barriers that discourage parents from engaging with services, including shame/stigma, lack of trust in services, fear of consequences, past negative experiences, lack of access to practical resources such as transport or childcare, and substance use/mental health issues. Lack of trust in, and fear of, mainstream domestic and family violence and child protection services may be especially prominent among Aboriginal and Torres Strait Islander mothers.*
- *At the service and systems-level, barriers to engagement can include workers' inadequate training about domestic and family violence/ what to do if a disclosure of violence occurs, lack of confidence responding to domestic and family violence situations, lack of time/time pressures, and negative attitudes towards victims/victim-blaming.*
- *Service perceptions about men/fathers represent a key barrier to engagement. Child protection workers may be reluctant to engage with fathers, see them as irrelevant, and/or purposefully avoid them. To overcome barriers to services' engagement with fathers who perpetrate domestic and family violence, early identification and involvement of fathers is a crucial first step.*
- *Many families where domestic and family violence is present have complex circumstances marked by interconnected factors that underlie and sustain domestic and family violence, such as parents' adverse childhood experiences (ACEs), substance use, mental health issues, and socioeconomic disadvantage. Parents with complex circumstances may be unable to effectively engage with interventions that place 'high demands' on them – such as behaviour change or parenting programs - until their more basic needs have been met.*
- *Addressing clients' complex personal situations and how those intersect with service use is a necessary first step in getting, keeping and engaging parents. 'Preparatory' work addressing parents' life circumstances can encourage engagement with interventions.*
- *Lack of worker training and knowledge can lead to responses that overlook the complex factors surrounding domestic and family violence and result in suboptimal or inappropriate referrals (including repeated referrals), which can in turn discourage parents' engagement.*
- *Responses should show cultural awareness, sensitivity, flexibility, and adaptability. For Aboriginal and Torres Strait Islander families who experience domestic and family violence, engagement is likely to be facilitated by a framework that takes into account historical circumstances and a legacy of extreme socioeconomic*

*disadvantage, as well as addresses the practical implications of greater levels of exposure to challenges such as substance use, financial insecurity, and housing instability.*

## 3. domestic and family violence in the context of other common parental risk factors among families in contact with the child protection system

As already highlighted, domestic and family violence frequently occurs in families with other stressors such as parental mental illness (which may or may not be formally diagnosed), substance use, histories of trauma (such as parental exposure to domestic and family violence during their own childhoods), and socioeconomic disadvantage (for example, unemployment and financial stress).[172] While any of these stressors in isolation can present a risk for child harm, Australia and international research consistently shows that as the number of adversities increases so does the risk of harm to children.[173] The more numerous, diverse, and severe those factors are, the greater the risk to children.[174]

For example, in Doidge and colleagues'[175] 27-year population-based birth cohort of 2443 Australians, the risk of child maltreatment increased exponentially with the number of risk factors experienced, with prevalence of maltreatment in the highest adversity groups exceeding 80%. Within a child protection context, parental mental health conditions and parental substance use, as well as parental history of maltreatment as a child, parental criminal history, and domestic and family violence in the previous year, have all been associated with recurrence in the Queensland child protection system.[176] The association between parental risk factors, child maltreatment, and other negative child outcomes, has been found by numerous studies using longitudinal methods and general population samples[177] (i.e., it is not a relationship that is only observed among families with child protection involvement). The interactions between different parental risk factors and stressors are complex,[178] and discussion of that complexity exceeds the scope of this review.

The presence of multiple significant adversities, including domestic and family violence, is prominent in systems-involved families where children experience chronic neglect,[179] and neglect frequently overlaps with physical, sexual, and psychological/emotional abuse. Differences in levels of parental exposure to multiple adversities have also been associated with the over-representation of Aboriginal and Torres Strait Islander families within the child protection system.[180] In families where multiple risks are present, short- and long-term impacts on children include compromised early brain development, emotional regulation, and cognitive development, impaired social attachments (beginning with insecure attachments with caregivers) and potentially life-long patterns of maladaptive interpersonal relationships (including subsequent domestic and family violence victimisation/perpetration in their own relationships), use of substances as a dysfunctional trauma coping mechanism, mental illness, homelessness, criminal behaviour, and poor educational attainment/school disconnection.[181] The presence of multiple adversities can also amplify the psychological and emotional impacts of domestic and family violence on children, through means such as increasing their sense of powerlessness.[182]

The triad of domestic and family violence, substance use, and mental illness has been shown to adversely affect the disciplinary practices of caregivers involved with child protection systems. For example, domestic and family violence, substance use, and mental illness are associated with psychologically and physically aggressive disciplinary practices. The likelihood of caregivers using these disciplinary practices tends to increase with the number of stressors they experience.[183] These practices place children at elevated risk of serious harm, including death.[184]

In addition to their relationship with domestic and family violence, parental substance use and mental illness are also frequently associated with 'household chaos' – that is, disorganised homes characterised by features such as noise, crowding, lack of routine, structure, and order. Some studies suggest that household chaos plays a moderating role in pathways between domestic and family violence and punitive parenting practices, finding that domestic and family violence is most likely to be associated with punitive discipline practices when household chaos is also high (this relationship was present even after controlling for exposure to other adversities and demographic covariates).[185]

Adversities such as housing instability are less well studied, even though involvement with child protection services is common among families experiencing inadequate housing conditions.[186] For example, Font and colleagues[187] used a nationally representative sample of US child protection investigations to explore the associations between inadequate housing/homelessness and system outcomes. They identified that, after accounting for other risk factors, inadequate housing was significantly associated with the child protection services involvement, but was not directly associated with either substantiation or case closure. They suggest that housing circumstances represent a service need that can flag the likely presence of other risk factors for child harm, and specifically highlight mental health, substance use, and domestic and family violence.[188]

## SERVICE RESPONSES TO COMPLEX CIRCUMSTANCES

In a child protection context, poor understanding of risk factors for child harm may lead to missed opportunities for intervention. For example, lack of attention to potential parental mental health problems in the context of child protection concerns has been raised as a missed opportunity to adequately assess levels of risk to children.[189] Child protection workers may incorrectly cite mental illness as a factor that mitigates parental accountability.[190] Conversely, some practitioners may view a parent indicating that they are receiving mental health treatment as indicative of child safety, in the absence of any other risk factors being addressed and/or the absence of consideration of how the parent's mental status may impact their parenting.[191] Much existing research has a gendered focus that considers mothers' mental health in the context of child protection, but overlooks fathers' mental health.[192]

System-level issues can also impact on responses to factors that elevate the risk of child harm. For example, Zannettino and McLaren's[193] South Australian study on the experiences of child protection workers who encounter domestic and family violence in complex situations suggested that workers rarely saw domestic and family violence without the presence of other factors, such as substance use and socioeconomic disadvantage. Workers reported that their ability to respond to those complex circumstances was negatively impacted due to statutory thresholds and frameworks surrounding their assessment of risk, 'low risk' rankings (such as when child exposure to domestic and family violence was considered 'emotional abuse'), and associated case closure practices.

Unless child protection workers have broader contextual knowledge and understanding, particularly regarding ongoing disadvantage, their decision-making can result in a poor match between family needs and services,[194] and leave the family's material circumstances and factors associated with domestic and family violence unaddressed.[195] Parents' complex circumstances often create difficulties for engagement. Substance use problems, in particular, are associated with parents not following through with service planning and receipt. Ferguson[196] discussed child protection practices for clients who have substance use problems, who do not want services and may be uncooperative or hostile toward caseworkers and the system. Ferguson[197] observed that an approach that responds to strong client resistance is only possible when caseworkers are highly competent and working in a setting that provides support for this extremely challenging professional practice.

Where parents are resistant to services, such as parents with substance use disorders,[198] caseworkers may assume that failure to comply with mandated tasks means parents are not motivated to change. In turn, caseworkers can perceive parents to be unwilling and overlook the factors affecting their parenting.[199] Directive practices have been found to be ineffective in promoting substance use treatment, while supportive approaches that acknowledge the often nonlinear process of recovery can contribute to positive outcomes.[200] In situations where parental substance use is present, service responses can face a difficult balance between protecting a child, and providing incentives for parents to address their problems.[201]

Differences have been observed between Aboriginal and non-Aboriginal mothers in the context of child protection involvement and substance use. For example, research conducted in Western Australia suggests that in the context of methamphetamine use, Aboriginal mothers are more likely to have children removed from their care, in part due

to their greater exposure to factors such as homelessness, unemployment, ongoing substance use, and mental health concerns.[202] To date, little consideration has been given to Aboriginal fathers in the context of substance use and child protection systems.

### INTERVENTIONS FOR PERPETRATORS IN THE CONTEXT OF 'DUAL DIAGNOSIS'

In recognition of the intersection between domestic and family violence, alcohol and other drugs and/or mental health concerns, and parenting, a small number of programs seek to support mothers with their substance use, mental health, and parenting issues in the context of domestic and family violence.[203] There has been far less attention given to fathers who use domestic and family violence and who also have substance use and/or mental health concerns.[204] Isobe and colleagues[205] highlight that in families where domestic and family violence, substance use, and mental health concerns are present, child protection practice has typically converged on mothers' accountability rather than the accountability of fathers, and has adopted a siloed approach rather than a collaborative strategy. Promising practice requires attention to intersections between domestic and family violence and other problems, and strengthening the intersections between domestic and family violence, substance use treatment and mental health practices with a focus on keeping the domestic and family violence perpetrator 'visible' to systems. It also requires a focus on children, without losing sight of the behaviours and needs of their parents.[206]

The relationship between domestic and family violence perpetration and substance use is particularly well documented,[207] including in child protection settings. domestic and family violence perpetrator substance use heightens the risks of severe/increasing violence (up to and including homicide) to (ex)partners and/or their children, particularly when co-morbid mental illness is also present.[208] There is considerable overlap between men who use domestic and family violence and men with substance use problems. Men who attend substance use programs routinely report increased likelihood of perpetrating domestic and family violence, while men who participate in MBCPs frequently report high levels of problematic substance use.[209]

There is consistent evidence that substance use is a contributory risk factor for perpetration of domestic and family violence, as well as for the development or worsening of mental health problems. However, little evidence exists for effective interventions for domestic and family violence perpetrators who also use substances even though men with substance use problems are more likely to reoffend after completing an MBCP than their counterparts without problematic substance use.[210] Research has also demonstrated higher prevalence rates of anger and trauma in domestic and family violence perpetrators who present with comorbid substance use,[211] along with an increased risk of mental health disorders where a substance use disorder is either the principal or comorbid diagnosis.[212] The intersection between domestic and family violence and substance use, along with other risk factors such as underlying childhood trauma[213] and mental health disorders[214] highlights the need for holistic responses to perpetrators of domestic and family violence that recognise complex support needs and physical, social and mental wellbeing.[215]

***Summary***

- *domestic and family violence frequently co-occurs in families with other stressors such as parental mental illness, substance use, histories of trauma (such as parental exposure to domestic and family violence during their own childhoods), and socioeconomic disadvantage (for example, unemployment and financial stress). While any of these stressors in isolation can present a risk for child harm, as the number of risk factors increases so does the risk of harm to children.*
- *domestic and family violence, substance use, and mental illness are associated with psychologically and physically aggressive disciplinary practices among caregivers involved with child protection systems. The*

*likelihood of caregivers using these disciplinary practices tends to increase with the number of stressors they experience.*

- *Poor understanding of these risk factors may lead to missed opportunities for intervention or for meeting children's and families' needs.*
- *Promising practice requires attention to the intersection between domestic and family violence and other parental risk factors, and strengthening the intersections between domestic and family violence, substance use treatment and mental health practices with a focus on children and keeping domestic and family violence perpetrators 'visible' to the system.*
- *A small number of programs seek to support mothers with substance use, mental health and parenting in the context of domestic and family violence, but far less attention has been given to fathers. There is little evidence about effective interventions for domestic and family violence perpetrators who also use substances even though men with substance use problems are more likely to reoffend after completing an MBCP than their counterparts without problematic substance use.*

## 4. Enablers and barriers for effective interagency collaboration and communication to address domestic and family violence within vulnerable families

Cross-sector collaboration is increasingly viewed as an indicator of best practice for working with children and families affected by domestic and family violence.[216] Within a child protection context, cross-agency collaboration is critical for the safety and wellbeing of children.[217] In Queensland, for example, statistics show a high level of overlap between men who perpetrate domestic and family violence and child maltreatment ('dual system contact'). Of males identified as being responsible for substantiated harm to a child, 58% had also been a respondent of a domestic violence order (DVO), and approximately 16% of male DVO respondents were identified as being responsible for substantiated harm to a child.[218] Indigenous men were more likely to have dual system contact. Dual contact was also found to be associated with more maltreatment events and more DVO orders/breaches.

It is argued that without addressing the comorbidity of risk factors (such as substance use and mental illness) observed among many perpetrators of domestic and family violence, and without maintaining men's 'visibility' across different agencies/sectors, neither their abusive behaviour nor the risk that their parenting poses to children can be addressed successfully.[219] However, in Australia and internationally, coordination or integration of services[220] remains uncommon,[221] and service system responses and interventions for domestic and family violence, child protection, substance use, and mental illness (as well as other needs) typically remain siloed from both a practice and funding perspective.

Different services generally approach problems from very different standpoints.[222] Services not working directly in child protection may give relatively little attention to children's wellbeing. For example, there are few mental health interventions that also focus on parenting support.[223] Within domestic and family violence services, the majority of focus is on mothers who are victims of domestic and family violence, rather than children. Against this general background, collaboration between 'mainstream' services and services for Aboriginal families remains inconsistent and is often overlooked, despite evidence that collaborative practices can improve Indigenous child outcomes including mental health.[224]

The need for increased collaboration and communication between the domestic and family violence and alcohol and other drugs service sectors has received particular attention.[225] Gilchrist and colleagues[226] found that few men with substance use problems had ever received support from domestic and family violence perpetrator

interventions, and a recent systematic review of domestic and family violence perpetrator interventions in health settings showed that interventions often exclude men with substance use disorders.[227] Conversely, alcohol and other drugs interventions have been criticised for a lack of domestic and family violence focused intake, assessment and practice.

Perpetrator accounts reflect this, with some research indicating that many participants in substance use programs state they had never been asked about domestic and family violence during intake or treatment for problematic substance use.[228] A small number of interventions seek to address both substance use and domestic and family violence perpetration, typically using a motivational and strengths-based approach.[229] Even though some promising initial findings have been reported, the evidence base remains too small to draw any conclusions about effectiveness,[230] and impacts on parenting/child protection concerns have not received focus to date.[231] Similar to other MBCPs, motivation appears crucial in driving change.[232]

Improved collaboration is seen as having the twin benefits of improving responses and making it simpler for families to navigate through different systems (for example, by reducing duplication of effort and avoiding overlap between different systems). Humphreys and colleagues,[233] reporting on interviews with 28 frontline workers from a range of organisations providing services to families experiencing domestic and family violence across three Australian states, suggest that a shared framework of child protection, substance use and mental health, that also recognises the overlap with domestic and family violence in all of those contexts, could bring practitioners from diverse sectors together to generate new ways of working.

### PRACTICAL BARRIERS AND POTENTIAL FACILITATORS TO COLLABORATION

Persistent barriers to collaboration between sectors/agencies have been observed by multiple researchers. While funding is frequently mentioned, ideological differences and fundamentally different treatment philosophies/practice principles have repeatedly been identified.[234] For example, Langenderfer[235] noted that within the domestic and family violence sector, many services operate from a feminist perspective and address the use of violence as the result of sociostructural factors around learned behaviour in a framework of patriarchal power and control,[236] rather than individual factors. In contrast, the mental health and substance use treatment sectors typically emphasise individual factors that may not adequately address broader life challenges and/or structural factors that sustain the use of domestic and family violence. Similarly, policing/legal responses to domestic and family violence may be seen to be at odds with therapeutic practice, not sufficiently framed around perpetrator accountability, and/or not adequately child-focused (depending on which sector is judging those practices).[237] There may also be disagreement over who the primary client is in domestic and family violence settings - the mother/victim, father/perpetrator, or child[238] - and about the extent to which responding to 'social risk' (such as socioeconomic disadvantage) falls within the remit of different agencies.[239]

In Australia, Humphreys and colleagues[240] note that contrasting practice models and knowledge bases create difficulties for collaboration. Also, while practitioners within different sectors appear to have a shared view about the importance of collaboration, in practical terms this can be impeded by different views about appropriate accountability frameworks for domestic and family violence perpetrators. For example, in interviews with Australian court, MBCP, alcohol and other drugs sector, and mental health sector representatives, Meyer and colleagues[241] found that while court and MBCP representatives felt there was sufficient evidence to support mandatory program referrals, alcohol and other drugs sector and mental health sector representatives were more inclined to support voluntary referral pathways to maximise motivation for change.

Numerous studies have examined systems-level facilitators and/or barriers to collaboration, from the differing perspectives of child protection, domestic and family violence, health (including mental health and/or substance use treatment settings), and policing. There has been relatively little study in contexts such as employment services[242] or housing services[243] and those have generally focused on women who experience domestic and family violence,

rather than children or perpetrators. Despite the different settings and sectors studied, findings are typically very similar.

Co-convened case planning meetings have been highlighted as particularly important for child safety when working with families where multiple risk factors are present,[244] however collaboration has been identified as insufficient in cases where domestic and family violence, parental substance use and mental health were prominent factors contributing to child deaths.[245] A key barrier to collaboration in the context of child protection is difficulty reconciling different roles/mandates of workers in their agency/discipline relative to their roles/mandates within a cross-agency response,[246] especially where many different agendas and goals are present[247]- including between police and child protection workers.[248] There may also be tension or confusion around statutory and non-statutory expectations of roles, such as a function to investigate allegations of child harm versus a function to provide social work/counselling responses.[249] In Queensland, operation of the Safe and Together model has been found to create increased collaboration and trust. However, challenges were still observed regarding how differing mandates created inherent tensions, as well as differences in philosophical orientations to domestic and family violence and child protection.[250]

A broader body of Australian and international research identifies that the consequences of not resolving such differences can include higher conflict in case review meetings,[251] erosion of trust between individuals/teams/agencies,[252] reduced willingness to share sensitive case information,[253] interagency conflict,[254] and dysfunctional cross-agency teams. The importance of openly identifying and acknowledging different perspectives and seeking to arrive at a holistic view – or 'common ground' – is frequently suggested as a facilitator to collaboration.[255]

Clear and comprehensive cross-agency protocols are one method that can assist in reconciling different mandates, roles and priorities, and enhancing communication, but this is only likely to be effective if protocols are developed and agreed to by each of the participating agencies. Protocols should be sufficiently clear to guide cross-agency practice and processes,[256] identify common standards such as culturally appropriate practice,[257] develop and use common terminology,[258] conceptual frameworks and (where relevant) screening tools,[259] formalise relationships with specialist service providers,[260] and contain principles for information sharing between agencies.[261]

Collaboration within child protection settings is also impacted by time restraints and lack of organisational prioritisation and/or administrative support of work such as case review meetings.[262]

Failure to resolve these challenges can impede communication and information sharing, which in turn are closely associated with the effectiveness of cross-agency responses. Looking at collaboration between child protection and mental health services in Queensland, Darlington and colleagues[263] found that around a third of reported difficulties between agencies related to poor communication and information sharing, particularly the perception that important case information was regularly withheld by other agencies. To facilitate collaboration, it is recommended that agencies communicate openly about:

- their considerations and proposed actions
- the exchange of information about a case
- the need for coordination on inter-related decisions and actions across agencies
- how confidentiality obligations can affect information sharing.[264]

In addition, cross-agency leadership and commitment to teams, and processes across agencies for resolving conflicts,[265] are important for addressing barriers,[266] as is genuine supportive leadership/management.[267]

At both the worker and organisational levels, there can be varying degrees of knowledge about inter-relationships between domestic and family violence, child protection, and other concerns, which can in turn affect workers'

perceptions about the need to collaborate with other sectors/services. Policies, procedures, and training should take this into account.[268] In Australia, for example, Battams and Roche[269] documented a lack of knowledge within the alcohol and other drugs sector about child welfare concerns and child and family sensitive policies and practices. They recommend cross-sectoral workforce development and retention strategies, including training in child development theories and approaches in the alcohol and other drugs sector, and addressing stigmatising attitudes towards parenting by alcohol and other drugs clients across other sectors.

Workers' skills and knowledge, not only about their own work but about ways to effectively collaborate with other workers outside their agency/sector,[270] are crucial. Lack of knowledge of other workers' roles and about services provided by other agencies,[271] along with inadequate communication skills and discipline knowledge, are well documented barriers to collaboration.[272] For instance, lack of knowledge about child protection by other sectors can lead to those sectors providing poor quality information to child protection services.[273]

Within a child protection context, practitioner preference to stay focused on single issues and the lack of evidence-based knowledge and training in more than one practice area have repeatedly been identified as key barriers to collaboration and the provision of holistic responses, whereas 'dual training' has shown positive results.[274] The need for more cross-sector training and supervision has been identified,[275] with many studies highlighting the importance of joint/cross-agency training. This brings different professional groups together for both learning and networking,[276] and building mutual knowledge of professional roles and understanding of the protocols and processes for working across agencies, including information sharing.[277] In a child protection context, some studies have found that workers' self-reported levels of cross-agency collaboration increased after training.[278] Other studies have identified improvements in workers' self-reported knowledge of the different professional roles within inter-agency teams following training.[279] However, it appears that enhanced collaboration after training may not persist over the long-term and that benefits may diminish over time (potentially, partly due to worker attrition)[280] highlighting a need for ongoing attention to skills and knowledge development within a cross-agency perspective.

Finally, a common understanding of risk factors can be crucial to facilitating collaboration and enhancing service responses in child protection settings.[281] Collins and Spencer[282] highlight that services' shared understanding about inter-relationships between domestic and family violence and other issues increases their likelihood of offering holistic responses and/or collaborating with other services/sectors. In addition to a role in promoting collaboration between sectors/agencies, a shared and evidence-based understanding of risk can also enhance practices within sectors – for example, by improving workers' level of knowledge about pattern-based domestic and family violence assessment,[283] and indicators of child lethality risk in the context of both domestic and family violence and child protection.[284] Despite the importance of such knowledge,[285] it has recently been documented that in Queensland, there remain notable gaps in practitioner knowledge about how to assess and respond to high-risk cases involving child protection and domestic and family violence concerns.[286]

### *Summary*

- *Within a child protection context, cross-agency collaboration is critical for the safety and wellbeing of children. Without addressing the comorbidity of risk factors (such as substance use and mental illness) observed in many perpetrators of domestic and family violence, and without maintaining men's 'visibility' across different agencies/sectors, neither their abusive behaviour nor the risk that their parenting poses to children can be addressed successfully.*
- *In Australia and internationally, coordination or integration of services remains uncommon, and service system responses and interventions for domestic and family violence, child protection, substance use, and mental illness (as well as other needs) typically remain 'siloed'. This may be attributed to several individual and organisational barriers such as different service delivery paradigms, difficulties in reconciling different*

*roles/mandates, lack of time to undertake collaborative work, lack of genuine supportive leadership and lack of common understanding of risk factors. These persistent barriers have been observed by multiple researchers to impact collaboration across the child protection and associated sectors.*

- *Clear and comprehensive cross-agency protocols are one method that can assist in reconciling different mandates, roles and priorities, and enhancing communication, but this is only likely to be effective if protocols are developed and agreed to by each of the participating agencies.*
- *At both the worker and organisational levels, there can be varying degrees of knowledge about inter-relationships between domestic and family violence, child protection, and other concerns, which can in turn affect workers' perceptions about the need to collaborate with other sectors/services.*
- *Within a child protection context, 'dual training' can be beneficial to improve workers' knowledge about risk factors and the need for collaboration. Cross-sector training has shown positive short-term improvements with practitioners' self-reported levels of cross-agency collaboration, however the benefits can diminish over time, in part due to workforce attrition.*

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[76] The programs discussed in this section are representative examples; not all fathering programs that have been trialled are included. For example, some programs (such as 'Strong Fathers' in the US) are not discussed although evaluations of those programs suggest broadly similar results to those presented in this review. In addition, not all programs have available evaluation data.

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