Safe & Together Addressing ComplexitY for Children

(STACY for Children)

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ANROWS acknowledges the Traditional Owners of the land across Australia on which we work and live. We pay our respects to Aboriginal and Torres Strait Islander Elders past, present, and future, and we value Aboriginal and Torres Strait Islander histories, cultures, and knowledge. We are committed to standing and working with Aboriginal and Torres Strait Islander peoples, honouring the truths set out in the Warawarni-gu Guma Statement.

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ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include 1800 RESPECT—1800 737 732 and Lifeline—13 11 14.

Contents

List of tables

List of figures

Abbreviations and acronyms

AIC	Akaike information criterion
AOD	Alcohol and other drugs
BIC	Bayesian information criterion
CIS	Critical interpretive synthesis
CoP	Community of practice
CP	Child protection
CPO	Child protection order
CSO	Child Safety Officer
CSSC	Child Safety Service Centre
DFV	Domestic and family violence
FRE	Family Risk Evaluation
FS	Family services
FV	Family violence
I&A	Investigation and assessment
ICMS	Integrated Client Management System
IPA	Intervention with parental agreement
ITS	Interrupted time series
MBCP	Men's behaviour change program
MH	Mental health
NGO	Non-government organisation
OOHC	Out-of-home care
PAG	Project advisory group
QDCSYW	Queensland Department of Child Safety, Youth and Women
S&T	Safe & Together
SDM	Structural decision making
STACY	Safe & Together Addressing ComplexitY

Glossary

All-of-family approach

The all-of-family approach is underpinned by feminist theories that attend to the intersection of multiple drivers of domestic and family violence (DFV) including sexism, racism, colonisation, ableism, homophobia and other forms of oppression. The approach involves working with each family member in the context of their family, extended family or community. The Safe & Together Model is an exemplar of this approach, and provides a high-level, ethical and transferable framework for conducting holistic and collaborative work across services and sectors. At a practitioner and organisational level, it involves keeping children safe and together with the non-offending parent; building an alliance with the non-offending parent by recognising and supporting her care and nurture of children; and intervening with the perpetrating parent to reduce risk of harm to adult and child victims/survivors and holding them to account for their use of violence and coercive control.

Child Safety Service Centre (CSSC)

Child Safety Service Centres (CSSCs) provide child protection services to children and youths and their families, including carers. They serve as a contact point for service clients and are located in Queensland.[1]

Child-focused practice

This phrase refers to inclusive practices that are informed by an understanding of child development and wellbeing. Child-focused practice considers:

- the child's experiences of, and perspectives on, their father's use of violence and coercive control toward their family
- how either or both parents' substance use and/or mental health issues impact the child.

Coercive control

This phrase refers to both physical and non-physical actions that constrain the behaviour of others, undermining their liberty, self-determination, and choices that they can make, attacking their quality of life and their physical and emotional safety. Coercive control creates significant fear in adult and child victims/survivors and thus harms the functioning of a family and a community. Perpetrator tactics include instilling fear by actual or threatened violence (to family members, partners, others, animals) or suicide, intimidating, humiliating, isolating, and micromanaging (such as through constant surveillance of) the daily lives of victims/survivors. It is a relentless form of abusive behaviour that is easily manipulated so as to exacerbate or cause mental health and/or substance use issues in victims/survivors. Regardless of the perpetrator's intention, coercive control can be a particularly egregious and effective way of isolating adult victims/survivors from family, friends, community and professionals; undermining the mother–child relationship; and contributing to systems abuse of victims/survivors. It is imperative that practitioners focus on the impact of the coercive behaviour rather than on the reported intention(s) of the perpetrator.

1 See https://www.csyw.qld.gov.au/contact-us/department-contacts/child-family-contacts/child-safety-service-centres

High expectations of men as fathers

Irrespective of men's mental health and/or substance use struggles, their parenting capacity should be assessed against the same standard of expectations as mothers. This means practitioners who work with fathers need to explore and document their care-giving role within the family, including the impact of their parenting choice in using DFV, on family functioning and, in particular, on children. It is highlighted as a way of counteracting the gender bias that informs interventions and systems, in which mothers and fathers are often treated differently. Setting a higher standard for fathers as parents than is usual merely means assessing them on the same criteria against which mothers are assessed. The point here is to develop a gender-responsive service system.

Intersections

Intersections between domestic and family violence, mental health and substance use refer to how one of those issues shapes the contours of the other issue, for example how DFV perpetrators' behaviours create the context for victims'/survivors' substance use patterns and related recovery challenges, or how mental health issues may be treated as the primary issue by providers while the perpetrator's violence is ignored or considered a symptom.

The term is differentiated from intersectional theory, which refers to women's differential experiences that are influenced by the intersections of interlocking forms of oppression including sexism, racism, ableism, homophobia and other aspects of identity. The experience of domestic violence is configured and compounded through these further points of discrimination.

Intervention with parental agreement

Intervention with parental agreement (IPA) is a form of ongoing intervention that is intended to prevent children and young people from entering the child protection system (Queensland. Department of Child Safety, Youth and Women [QDCSYW], 2020). In cases where parents are willing and able to collaborate with child protection authorities to ensure that their children's needs are met, IPAs can be used to allow the child to remain with the family during the ongoing intervention.

Pattern-based

"Pattern-based" is used in contrast to an "incident-based" or "single incident" approach when referring to a father's pattern of behaviours that he chooses to use to harm and control adult and child members of his family. In an "incident-based" approach, the perpetrator's pattern of behaviour can become de-contextualised and reduced to a "single event", usually of physical violence. The trauma lens, while important, can be used to divert attention from the wider undermining of family functioning, which is equally important. While incidents may be important, there is always a danger that practitioners miss the full extent of his violence and coercive control so that it becomes invisible or diminished with dangerous consequences for adult and child victims/survivors. Adult victims/survivors can be frequently misidentified by police attending a DFV incident as the primary aggressor or offender.

Perpetrator

This descriptor is used frequently through the report to refer to men or fathers who use violence and coercive control toward their family and community. We recognise that it is preferable to separate "the man" from his "behaviours", however, at times the use of the phrase "fathers who use violence and coercive control" is cumbersome. We use "perpetrator" as a shorthand term and a term which has broad usage across systems, including criminal justice and child protection. We also are focusing on the dominant gendered pattern of men's violence against women and children.

Executive summary

The "Safe & Together Addressing ComplexitY for Children (STACY for Children)" project was undertaken as an extension of the suite of research activity informed by working with the Safe & Together Institute (founded by David Mandel) which includes the following projects: "PAThways and Research Into Collaborative Inter-Agency practice (PATRICIA)"; "Invisible Practices: Working with fathers who use violence (Invisible Practices)"; and "Safe & Together Addressing ComplexitY (STACY)".

The STACY for Children project (2019–20) involved two studies that investigated whether there was emerging evidence that the Safe & Together™ Model, where it is implemented holistically, is leading to better outcomes for children and families living with domestic and family violence (DFV) and parental issues of alcohol and other drugs (AOD) use and/or mental health (MH) problems. The project arose through interest from participating organisations in the STACY and Invisible Practices projects (Healey, Humphreys, Tsantefski, Heward-Belle, & Mandel, 2018) and was designed through discussion between researchers, practitioners and managers from these organisations, as well as the Queensland Department of Child Safety, Youth and Women (QDCSYW). It took place in the context of the *Fourth Action Plan—National Plan to Reduce Violence against Women and their Children 2010–2022*. Priority Five of the National Plan identifies the need to improve support and service system responses by enabling cross-sector collaboration and responsiveness and by building the evidence base for what works to reduce violence (Commonwealth of Australia. Department of Social Services, 2019).

Study 1 focused on listening to the voices of those working and living at the intersection of DFV, AOD and MH. Researchers gathered perspectives from practitioners and from clients from participating organisations about the implementation of an all-of-family approach to practice (i.e. each family member receiving attention or a service at intake). The services offered by participating organisations operate within a range of sectors, including family violence, child protection, family services, and AOD, MH and justice services.

Study 2 explored the implementation of the Safe & Together (S&T) approach in a particular trial site where a specialist worker is placed to support and inform the child protection process from a DFV-informed perspective. It used child case-level, de-identified administrative records to investigate whether the availability of the S&T Model as an approach to practice was associated with positive outcomes for children and families in an area where it had been proactively implemented. It is important to note that it was not the aim of this study to evaluate the effectiveness of S&T itself, but to conduct an exploratory analysis of the early impacts of the availability of S&T on child protection process outcomes at the trial Child Safety Service Centre (CSSC). This distinction is crucial, especially considering the short follow-up period available for the presented analyses.

Background

Children as well as adults may be victims of DFV. Children's exposure to DFV often has destructive consequences for them, as has been well established in the literature (McTavish, MacGregor, Wathen, & MacMillan, 2016). These include negative health impacts (Riviara et al., 2007), the undermining of children's emotional and psychological wellbeing (Holt, Buckley, & Whelan, 2008), and problems connected with damaging behaviours (Kimball, 2016). Although DFV is widely recognised as predominantly concerning men's violence towards women (Cox, 2015), children's experiences of their fathers' destructive parenting behaviours in the context of DFV are given less attention. Research about practice with children and families living at the intersection of DFV and AOD and MH issues has highlighted the need to support each family member in their own right. The evidence suggests that this should be done through suitable and targeted interventions that focus on holding perpetrators accountable for their abuse, and partnering with the non-offending parent to develop appropriate responses for ensuring the safety and wellbeing of women and children. Such approaches combat entrenched practices that render fathers who use violence invisible, converge judgementally on mothers through "failure to protect" frames, and result in inattention to the actual impacts on children and their unique needs for recovery (Healey, Humphreys, Tsantefski, Heward-Belle, & Mandel, 2018; Stanley & Humphreys, 2017).

The Safe & Together™ Model

The Safe & Together (S&T) Model consists of an ethical framework for an all-of-family approach to practice in circumstances where both DFV and intersecting complexities such as AOD and/or MH issues are present. The model supports practitioners and organisations across sectors (DFV, AOD, MH, child protection, family services, justice services etc.) to become more DFV-informed in their individual and organisational practices, and to develop multi-disciplinary, multi-agency collaboration across the service system that is sensitive to DFV and intersecting complexities that impact on children and families. It is an approach that focuses on the perpetrator's pattern of abuse and coercion (rather than taking a single-incident focus). The framework also attends to the dynamics of DFV where there are intersecting complexities, as well as the risks perpetrators pose to adult and child victims/survivors and how to manage these. The model is underpinned by core principles and critical components that:

- cultivate ways of working that focus on keeping children safe and together with their non-offending parent (usually the mother)
- partner with the non-offending parent to take a default position that supports her efforts to care for and nurture the safety and wellbeing of her children
- intervene with perpetrators as parents to reduce the risk of harm and increase accountability for their use of violence and coercive control.

Research questions and methodologies

The research questions for the two STACY for Children studies are presented below. Questions 1 and 2 relate to Study 1, and questions 3, 4, and 5 to Study 2.

Study 1: Listening to the voices of people working and living at the intersection of DFV, AOD and MH

1. How do individual family members experience the interventions they receive when they are clients of an organisation that is implementing the Safe & Together Model when working with children and families living with DFV and where there are parental issues of MH and/or AOD?
2. How have practitioners experienced the implementation of the collaborative Safe & Together Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

Study 2: Exploratory quantitative analyses of the wider impact of Safe & Together in intervention regions

1. Have there been higher rates of DFV identified in the trial site following the introduction of Safe & Together compared to comparison areas?
2. How have children's and families' post-substantiation child protection outcomes changed since the implementation of a DFV-informed Safe & Together approach to child protection?
3. What are the intersecting complexities of DFV, AOD and MH and how do they relate to children's pathways through the child protection system?

Study 1 drew on several sources of data collected as part of the STACY project (2018–19) and re-analysed them with a focus on children's needs and perspectives. This secondary analysis enabled a deepened understanding of practitioners' perspectives on the implementation of the S&T Model as an all-of-family approach to practice. Critically, it brought forward the voices of children/young people and family members living at the intersection of DFV, AOD and MH who had experienced this implementation as part of their engagement with services. Sources of data included:

- notes from the STACY project communities of practice (CoPs)
- qualitative data drawn from a survey of STACY CoP participants and secondary participants (professionals who did not attend the CoPs but were trained by CoP participants)
- quantitative data drawn from the DFV-informed continuum of practice exercise conducted with CoP participants

- interviews with practitioners implementing the Safe & Together Model
- interviews with mothers, fathers and young people who were clients of organisations implementing the model.

Study 2 explored quantitative data from child protection in an area where the S&T Model had been proactively implemented. The study investigated whether any changes implemented through the DFV-informed intervention could be identified at the aggregate child protection system level. In other words, the research team investigated whether the introduction of S&T may have had wider effects on the child protection system in the region. To do so, a variety of analytical approaches were applied including descriptive analytics, pre–post analyses and non-equivalent comparison group designs. While the study did not attempt to generate any causal interpretations of observed relations in the data, it was designed with a view to informing the feasibility of a larger scale investigation into the effects of the implementation of S&T within child protection systems in Australia.

Research sites and participants

The STACY for Children project was conducted across three research sites in Queensland, New South Wales and Victoria by a collaborative, multi-disciplinary team of researchers.

As described above, Study 1 drew on data collected as part of the STACY project, driven by a team consisting of S&T consultants, researchers and chief investigators based in each site (n=12). The STACY project was underpinned by action research methodology and involved collaboration with a project advisory group (PAG) at each site consisting of senior representatives from government and participating organisations across DFV, AOD, MH, statutory and non-statutory child protection, justice and family services (n=58 individuals from 33 organisations). Senior practitioners from these organisations (n=87) participated in state-based CoPs (supported by their PAG members); "secondary participants" (n=278) were those that CoP members chose to mentor with emerging practices from the CoP learnings. This latter group of CoP members and secondary participants formed the core pool of project participants. CoP members received three days of S&T training from Safe & Together Institute consultants and implemented the model within their own practice, as well as coaching secondary participants in using the model to inform their practice. CoP members and secondary participants were the respondents to the online STACY project questionnaire, and the DFV-informed continuum exercise. This exercise asks participants to reflect on where they would place themselves on a continuum from destructive to proficient DFV practice. In addition, interviews were carried out with 28 practitioners across five organisations, and 23 clients (13 mothers, five fathers and five young people) accessing services at four organisations. Of these interviews, 21 were conducted for the STACY project, and re-analysed for STACY for Children.

Study 2 was conducted in collaboration with QDCSYW. University of Melbourne researchers worked closely with the Data Analysis and Reporting Unit at QDCSYW to develop a feasible data extraction plan and identify five comparison sites. With the support of QDCSYW, potential data sources were selected. Furthermore, QDCSYW assisted the research team with the identification of comparison Child Safety Service Centres (CSSCs). Overall, the data extracts available for the analyses included all child protection notifications recorded in each of six CSSCs between 1 April 2013 and 31 March 2019. Overall, these extracts included 24,571 child-notification observations. The data were subject to several limitations which ultimately led to a substantial reduction in sample sizes (see section 3.6.1).

To answer each of the research questions of Study 2, different datasets were generated. In general, data were aggregated to notification levels for the analysis, to reflect child protection decision processes and to address the strong correlations of information recorded for children subject to the same notification event. Furthermore, the data were likely to be incomplete due to data extraction processes employed for periodical reporting (see Appendix E). In the end, analysis samples for research question 3 included 4955 notifications that had associated family risk evaluations recorded between 1 April 2014 and 31 December 2018. The sample used for the investigation of research question 4 consisted of 1083 notifications that had approved assessment processes between 1 April 2014 and 31 December 2018. Finally, the dataset

employed during analysis of research question 5 included 947 notifications that had finalised Investigation & Assessment (I&A) phases and associated family risk evaluation forms.

Key findings

Study 1: Listening to the voices of people working and living at the intersections of DFV, AOD and MH

Practitioners in the STACY project who had received training in the S&T Model were using it in their practice and discussing it in the CoPs. They reported an increase in the degree to which they recognised the centrality of children in perpetrator patterns of power and control and the multitude of ways that children are impacted by DFV, parental AOD use and MH issues. This is a significant shift away from historic representations of children as incidental, silent or invisible victims of DFV, whose risks and needs are conflated with those of their mothers. Young people, mothers and fathers who were interviewed as part of the study were able to identify positive differences in approach between workers who had been trained in S&T and their previous experiences with workers. They mentioned significant changes in their families and being treated respectfully by practitioners.

It is clear from the evidence, however, that DFV-informed work with children is still in its infancy. Challenges to integrate adult-focused practice with children and their needs, and to recognise child safety and wellbeing as being tied to that of the non-offending parent, are felt particularly in adult-focused services, but also across sectors, in child protection and family services, DFV services and the AOD and MH sectors. In interviews and questionnaire responses, and in CoP discussions, children were discussed as a motivating factor to engage violent fathers, or in relation to removal from the family home. They were less often seen as individuals with agency who were victims/survivors of DFV themselves and had their own expertise about factors contributing to their own safety and wellbeing. From the perspective of young people, practitioner confidence and skill in engagement underpins the success of an intervention.

The findings from the continuum exercise reinforce this picture of change in its infancy, with some variation across sectors. Not surprisingly, practitioners from adult-focused services in MH and AOD were less confident in their personal and organisational practices. AOD practitioners reported significant change, particularly in understanding the concept of child safety and wellbeing being tied to the adult victim/survivor. However, MH organisational and personal practice was reportedly much less responsive to this idea. Overall, although there was a perceived improvement in organisational practice and even more so in personal practice for organisations and practitioners involved in the CoP capacity-building process, respondents believed that further change was necessary. Organisational practice, despite improvement, was seen to remain at a "pre-competent" level in relation to DFV-informed, child-focused work. Starting from a slightly higher base, personal practice was perceived to have improved to "competent" levels. Neither was seen as "proficient".

Effective child-focused practice at the intersections of DFV, AOD and MH does not become embedded in organisational and practice culture without an authorising environment that involves DFV-informed and child-focused policies and procedures, and training of staff at all levels to increase both skills and confidence. Some very effective change has occurred as a result of organisations structuring an all-of-family approach into practice. However, there is a long way to go across all sectors to re-orient service systems to the principles of the S&T Model.

Study 2: Exploratory quantitative analyses of the wider impact of Safe & Together in intervention regions

Overall, the findings from this study show mixed results. In graphical analyses, some increases in DFV reporting were observed in the trial site (Site C) following the introduction of the S&T Model in October 2016. However, it is not clear from the data if, and to what extent, the intervention itself contributed to these changes, as competing causal explanations could not be ruled out.

The effects of the S&T Model on children's trajectories through the child protection system was investigated in two

ways. First, the rate at which practitioners made plans for interventions with parental agreements (IPAs) during intake and assessment was examined. While an increase in plans for IPAs was identified, statistical analyses were not able to confirm that any changes in these rates were a result of the introduction of a DFV-informed child protection approach in Site C.

Second, the relationship between the introduction of S&T and out-of-home care (OOHC) placement for children in need of protection was considered. Estimates showed substantial decreases in the probability of OOHC placement over time. However, as these trends commenced prior to the introduction of the intervention and were similar to developments in other CSSCs, the role of S&T in these changes is unclear.

An analysis of available family risk evaluations showed that DFV was most often reported in combination with other risk factors. In particular, the co-reporting of DFV with both AOD and MH issues was by far the most prevalent pattern across CSSCs. Graphical analyses indicated that the reporting of all three risk factors—DFV, AOD and MH—in Site C, as a proportion of all family risk evaluations, increased substantially after the introduction of S&T in October 2016. Further analyses into the relationships of DFV with the two other risk factors revealed that these associations are based on complex profiles that also involve other family risk factors.

In conclusion, the analyses showed promising signals in the data that point towards positive developments in all investigated outcomes over time at Site C. However, in light of data limitations and the complexity of the child protection and family violence sector in Queensland during the period of observation, a more targeted and comprehensive analysis is required to determine the contribution of S&T to these changes.

Implications for practice

Across the two studies, the S&T training, coaching and supervision on practitioners and clients indicated positive directions for practice. Data drawn from both family member interviews and consultations with professionals indicate that the practice of workers trained in the S&T Model, and coached in implementing the model, showed an increasing recognition of the importance of assessing children, parenting and family functioning in any DFV intervention.

The implications of these findings for practice need to be seen in conjunction with the discussion on implications for policy. An artificial distinction has been made, given that policy and practice initiatives interact with each other, and the development of policy and practice derives from practice expertise on the one hand and managerial support, policy development and leadership on the other.

RECOMMENDATION 1

The Safe & Together Model continues to be explored with practitioners across different sectors to ensure a more ethical and DFV-informed approach to practice. In particular, continued peer support and engagement through CoPs across sectors would enable cross-sector sharing of practice expertise to inform both policy and practice.

RECOMMENDATION 2

The co-occurrence and interconnections between DFV, MH and AOD are incorporated into the training, supervision and coaching of practitioners across all relevant sectors.

The co-occurrence of AOD and MH issues within families where there is DFV is confirmed in the analysis of Australian child protection data (Australian Institute of Health and Welfare, 2020) and should be reflected in the training, supervision and coaching of practitioners across different sectors (Frederico, Jackson, & Dwyer, 2014). In particular, the strategies for keeping the perpetrator of DFV in view, and for understanding the ways in which AOD and MH issues are used as part of wider tactics of coercive control, require training and focus. This will embed practice that moves beyond identifying the co-occurrence of these issues towards an understanding of how they are intersecting and connected (Isobe, Healey, & Humphreys, 2020).

RECOMMENDATION 3

Increased attention and focus is given to strategies, programs and resources that recognise adults as parents and enhance visibility of their children in DFV, AOD and MH interventions.

Children are continuously lost from view in the different parts of the service system, particularly, but not only, in adult-focused services. Throughout the study, keeping a direct focus on children was given less attention by practitioners than engagement with fathers or partnering with mothers.

Implications for policy

The need for system-wide changes is highlighted as a key finding and a complex area to address. Practitioners involved in implementing the Safe & Together Model reported their direct practice to be moving ahead of that of their organisations, in relation to creating visibility of children, holding a focus on adult clients as parents, and keeping all family members in view around tactics of coercion and control.

RECOMMENDATION 4

Senior managers in MH, AOD and DFV organisations proactively develop policies for their staff to facilitate conversations about the role of their clients as mothers and fathers, and how to increase the visibility of children.

RECOMMENDATION 5

Senior managers in MH, AOD, child protection and family service organisations develop protocols, following the STACY project's Practice Guides (Heward-Belle et al., 2020), that address the intersection of DFV with other complex issues challenging the families seen in their organisations.

A significant policy issue arises from this study about the ways in which senior managers in organisations can provide practice and procedural guidance to practitioners to allow them to move beyond a single-issue/single-adult focus to address the intersections between DFV, AOD and MH, and recognise their clients as parents with responsibilities and accountability to other family members.

RECOMMENDATION 6

Senior managers in MH, AOD and DFV organisations:

- facilitate the training of a group of practitioners in their organisation to be children's specialists, working directly with children to understand their perspectives; or
- employ a specialist worker who can provide appropriate secondary consultation about children in the organisation.

In adult-focused services, this will potentially involve the specialised development of brief counselling formats or assessment processes with a focus on children.

Another key area for further policy development is child-focused work. In the CoP discussions, there were only a few examples of practitioners working directly with children, even in child-focused and family organisations, and this is an area where further development is needed. Children and their mothers highlighted their positive experiences of direct work with children when this occurred. Similarly, service experiences where practitioners identified the strengths of women supporting their children through the challenges of DFV were also received particularly positively and contrasted with other interventions where mothers found themselves "under surveillance".

RECOMMENDATION 7

Sector leaders and agency managers adopt a policy position that keeps children safely with their mothers as the default starting point for practitioners in their agencies. This recognises the importance of supporting the relationship between non-offending parents (usually mothers) and their children.

RECOMMENDATION 8

The serious lack of MH services for children and young people living with DFV, highlighted as a service gap, is urgently addressed.

The lack of MH services for children was a particular concern raised by women and practitioners, who recognised the trauma that many children were carrying that was impacting on their behaviour and their development.

Implications for research

Study 1 highlighted the importance of hearing the compelling stories of those with lived experience of the service system where there are issues of DFV and also MH and/or AOD. While the issues of keeping children in view were highlighted, the study also identified gaps and the need for further research. In particular, we note that only five children and young people were able to be interviewed. Part of the invisibility of young people and children within the service system revolves around the difficulty involved in directly hearing their voices and their experiences of the service system. They do, however, have a right to participation and to be heard.

RECOMMENDATION 9

A project titled "STACY *with* Children" rather than "STACY *for* Children" be undertaken as an important further step in the exploration of the experiences of children and young people who are involved in the service system where there are intersecting issues of DFV, MH and AOD. As in previous projects, workers trained in working with the S&T Model would be engaged in the research.

There were other voices that were notably absent in this research. In particular, the direct experiences of Aboriginal and Torres Strait Islander children, mothers and fathers are missing. Given the over-representation of Aboriginal and Torres Strait Islander children in the child protection system this is a significant absence that needs to be addressed.

RECOMMENDATION 10

An Aboriginal and/or Torres Strait Islander-led project is undertaken which explores holistic approaches to children, women and men where there is DFV and intersecting issues of MH and AOD. This could include the development of practice tools that are co-designed and customised to Aboriginal and Torres Strait Islander families and their communities, and potentially informed by the S&T Model and its resources.

In Study 2, the analysis of a state child protection administrative database highlighted the challenges but also the potential use of administrative data, supported by additional sources of information, to understand trends and to answer pertinent research questions with the data. The results of this pilot study point to some interesting changes following the implementation of the S&T Model. However, as is outlined in detail throughout the report, Study 2 was subject to several limitations that restricted a full investigation of the effects of the DFV-informed child protection intervention in the trial area. Nevertheless, these limitations could largely be addressed through a research question-specific study design and data extracts. These points are outlined in the following recommendations and a detailed description is available in section 3.6.1 of the full report.

RECOMMENDATION 11

Future research on the impacts of S&T on child protection practice and outcomes for children include the following initiatives:

- a cohort-based study design at the child-notification level
- development of a dataset specifically tailored to the focus of the study, including additional items from the Integrated Client Management System (ICMS) and extended periods of observation
- linking of additional information to data extracted from the ICMS
- expansion of the analysis to include multiple treatment groups and comparison centres.

A targeted research design will enable more comprehensive investigations into the effects of S&T on child protection practice, and consequently, the pathways of children and families through the statutory child protection process. Moreover, such a study could provide new learning into the interactions between risk factors and their relations to DFV in Australia.

Conclusions

The two studies that constituted the STACY for Children project have brought different perspectives to the issues under consideration. Study 1 has enabled the researchers

to examine in detail the thoughts and experiences of both professionals and family members with lived experience, in relation to DFV-informed, child-focused practice. The CoP model methodology for capacity-building DFV-informed practice has supported and recorded emerging and very positive practice in this complex area.

Study 2, through an analysis of the administrative child protection database, indicated interesting changes in a positive direction following the implementation of S&T. The limitations faced by this study have enabled researchers to set out clearly what is needed for further analysis if the administrative database is to more accurately link practice developments to changes in child protection data.

Bringing the findings of the two studies together, the STACY for Children project points the way to further research and practice development in building greater child focus and engagement into DFV-informed practice across a number of services, highlighting the intersections in particular with MH and AOD services.

CHAPTER 1:

Introduction, background and research questions

1.1 Project rationale

Evidence highlights that children as well as adults may be victims/survivors of domestic and family violence (DFV). Children's exposure to DFV often has destructive consequences, as has been well established in the research literature (McTavish, MacGregor, Wathen, & MacMillan, 2016). These include negative health impacts (Riviara et al., 2007), the undermining of children's emotional and psychological wellbeing (Holt, Buckley, & Whalen, 2008), and problems connected with damaging behaviours (Kimball, 2016). Although DFV is widely recognised as predominantly concerning men's violence towards women (Cox, 2015), children's experiences of their father's destructive parenting behaviours in the context of DFV are given less attention.

The "Safe & Together Addressing ComplexitY" (STACY; 2018–19) and the "Invisible practices: Working with fathers who use violence" (Invisible Practices; 2017–18) projects highlighted the challenges of keeping perpetrators of violence and abuse in view. This issue was compounded when other issues such as mental health (MH) problems and/or alcohol and other drugs (AOD) issues emerged or co-occurred with DFV. Alongside this, an issue emerging from the STACY project appeared to be a tendency for the needs of children to become invisible, particularly in adult-focused services (MH, AOD and to a lesser extent DFV). It was an area where the research team considered further research was needed.

This research has taken place in the context of the *Fourth Action Plan— National Plan to Reduce Violence against Women and their Children 2010–2022* (the National Plan). Priority Five of the National Plan identifies the need to improve support and service system responses by enabling cross-sector collaboration and responsiveness and by building the evidence base for what works to reduce violence (Commonwealth of Australia. Department of Social Services, 2019). This report is a contribution to these objectives.

Through the training and coaching by Safe & Together Institute consultants, inroads to a more DFV-informed practice have been made in some child protection organisations and NGOs (Healey et al., 2020). Organisation managers were interested to know whether the implementation of the Safe & Together framework might have an impact on practices within child protection offices, where there had been a strong attempt to capacity-build the workforce through training and coaching to the Safe & Together™ Model.

1.2 Project aims

The overall aim of this project, "Safe and Together Addressing ComplexitY for Children (STACY for Children)", is to identify whether, and to what extent, there is emerging evidence that the Safe & Together (S&T) Model, where it is implemented holistically, is leading to better outcomes for children and their families living with DFV where there are parental issues of MH and/or AOD use. The project was designed following discussion with researchers, practitioners and managers from the Queensland Department of Child Safety, Youth and Women (QDCSYW).

The first line of inquiry was to re-analyse qualitative data collected in the STACY project from two sources: 1) interviews with clients who had worked with practitioners trained in the S&T Model; and 2) practitioners who had been trained and coached within the framework. The data were re-analysed to determine whether children's needs were addressed in the context of the complexities of living with DFV and parental issues of MH and/or AOD use. Original data collected from two additional client interviews supplemented the re-analysed data.

In this aspect of the project, particular attention was paid to whether children's needs were addressed in the context of the complexities of living with DFV and parental issues of MH and/or AOD (Study 1).

The second line of inquiry was to ascertain whether the stories from clients were reflected in quantitative findings derived from a child protection database. An area which had proactively implemented the S&T Model was selected to explore whether changes in the patterns of the use of parental agreements, re-notifications and children coming into care could be discerned (Study 2). While the S&T framework was

not designed to actively focus on preventing entry into out-of-home care (OOHC) or re-reports of incidents, there was interest to know whether there may have been an indirect impact on the patterns of work as seen in the administrative child protection database.

1.3 Report structure

The report commences with an outline of the STACY for Children project research questions and a brief summary of the Safe & Together Model which provides the common backdrop to the qualitative and quantitative studies. A short literature review is written as an adjunct to the published, open source article that was developed from the international review conducted as part of the STACY project.[1] The report then presents Studies 1 and 2 separately, with the methodology and ethics, findings and discussion for each fully reported. A final synthesis section follows, where implications for policy, research and practice from both studies are discussed.

1.4 Research questions

The research questions for the STACY for Children project are presented below. Questions 1 and 2 relate to Study 1, and questions 3, 4, and 5 to Study 2.

Study 1: Listening to the voices of people working and living at the intersection of DFV, AOD and MH

1. How do individual family members experience the interventions they receive when they are clients of an organisation that is implementing the S&T Model when working with children and families living with DFV and where there are parental issues of MH and/or AOD?
2. How have practitioners experienced the implementation of the collaborative S&T Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

Study 2: Exploratory quantitative analyses of the wider impact of Safe & Together in intervention regions

1. Have there been higher rates of DFV identified in the trial site following the introduction of S&T compared to comparison areas?
2. How have children's and families' post-substantiation child protection outcomes changed since the implementation of a DFV-informed S&T approach to child protection?
3. What are the intersecting complexities of DFV, AOD and MH and how do they relate to children's pathways through the child protection system?

1.5 The Safe & Together™ Model

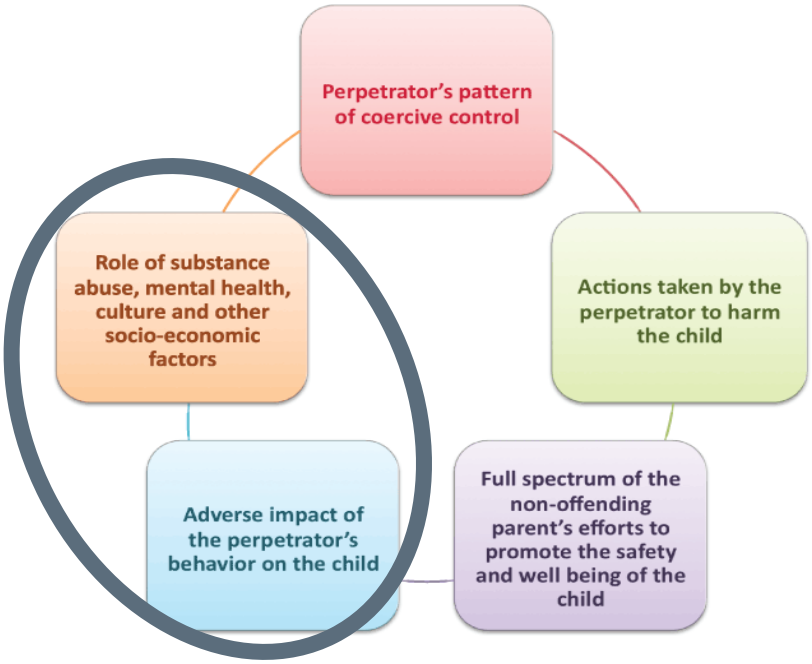
The S&T Model is a systems intervention framework that was developed to guide organisations and their practitioners working with child protection issues to policies and practices that are DFV-informed. The research team's interest in the model has its roots in practice issues for child protection and family services workers intervening with children and their families where there is DFV (Humphreys & Healey, 2017). The research team has collaborated with the Safe & Together Institute and its consultants in a series of projects that explore and utilise the model to inform and capacity-build practice in Australian organisations. Each of the projects has informed the next, from the "Pathways and Research In Collaborative Inter-Agency working" project (PATRICIA), to the "Invisible practices" project, and the "STACY" project, leading into "STACY for Children". For the last project, reported on here, Safe & Together Institute consultants provided training and coaching to 91 professionals working in 31 organisations across three states (nine organisations in New South Wales, nine in Queensland, and 13 in Victoria). Organisations operated within a range of sectors, including DFV, AOD, MH, child protection, family services and justice services.

The S&T Model's principles and critical components are reproduced with permission in Figures 1 and 2 below. Both STACY and STACY for Children have a particular focus on the component in Figure 2 that concerns the roles of AOD use, MH and other issues—particularly the intersections of DFV, AOD and MH. The STACY for Children project focuses

1 Isobe, J., Healey, L., & Humphreys, C. (2020). A critical interpretive synthesis of the intersection of domestic violence with parental issues of mental health and substance use. *Health and Social Care in the Community*.

Figure 1: Safe & Together™ Principles (reproduced with permission)

Figure 2: Safe & Together Critical Components (reproduced with permission)



Source: https://safeandtogetherinstitute.com/safe-together/safe-together-overview/assumptions-principles-critical-components/

also on the component that relates to the adverse impact of perpetrator actions on the child. However, the focus in this project is broader than this one component: the project concerns how these aspects are connected with the role of parental AOD use and MH issues, cutting across these two critical aspects of practice (see circled components in Figure 2).

The safety and wellbeing of children living with DFV is at the core of the three principles (see Figure 1). Practice informed by the model is able to be customised, and means keeping children "safe and together" with the non-offending parent (the adult victim/survivor who is usually the mother), partnering with her and being involved with the perpetrator in ways that strengthen the safety and wellbeing of children while holding him to account for his use of violent and controlling behaviours. It requires intervening with the perpetrator in order to reduce the harm and risks to children.

Keeping children's safety and wellbeing in view is achieved through both intervening with the perpetrator and partnering with the adult survivor (usually the mother). In S&T language, intervening with the perpetrator and disrupting his pattern of abusive behaviour is often referred to as "pivoting to the

Figure 3: Safe & Together's five-step Mapping Perpetrators' Patterns Practice Tool

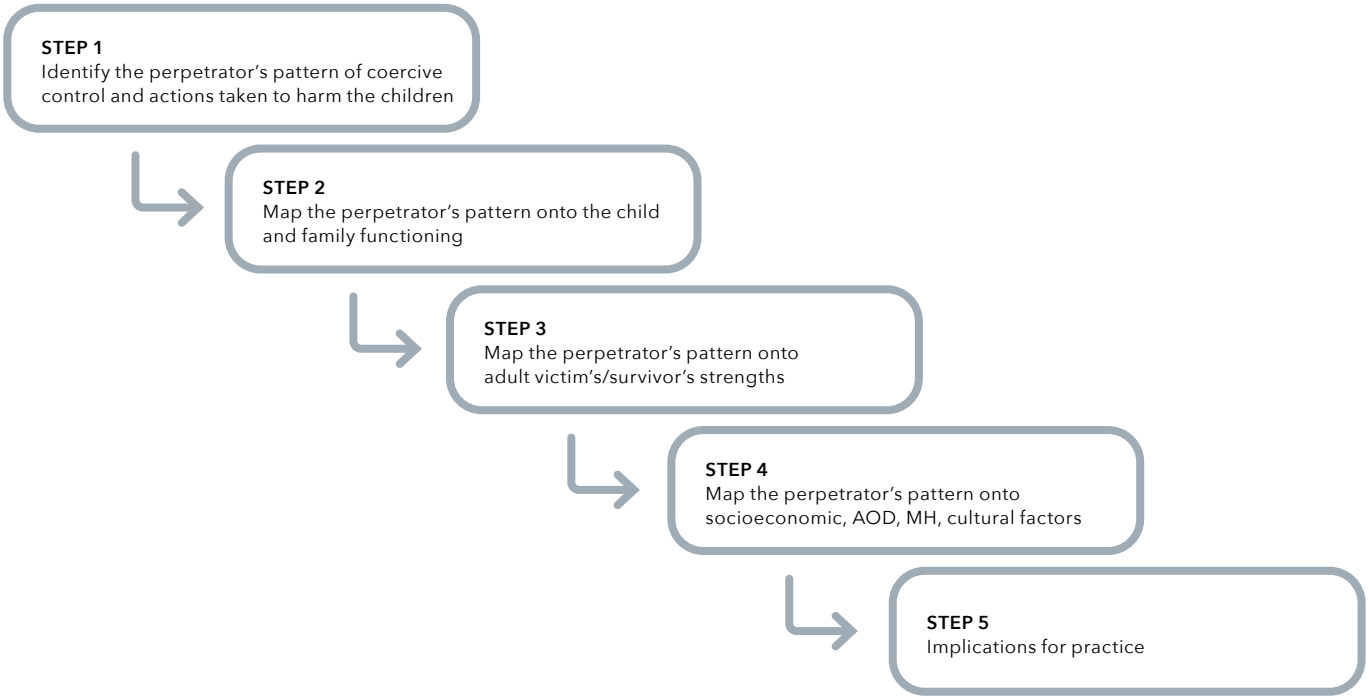
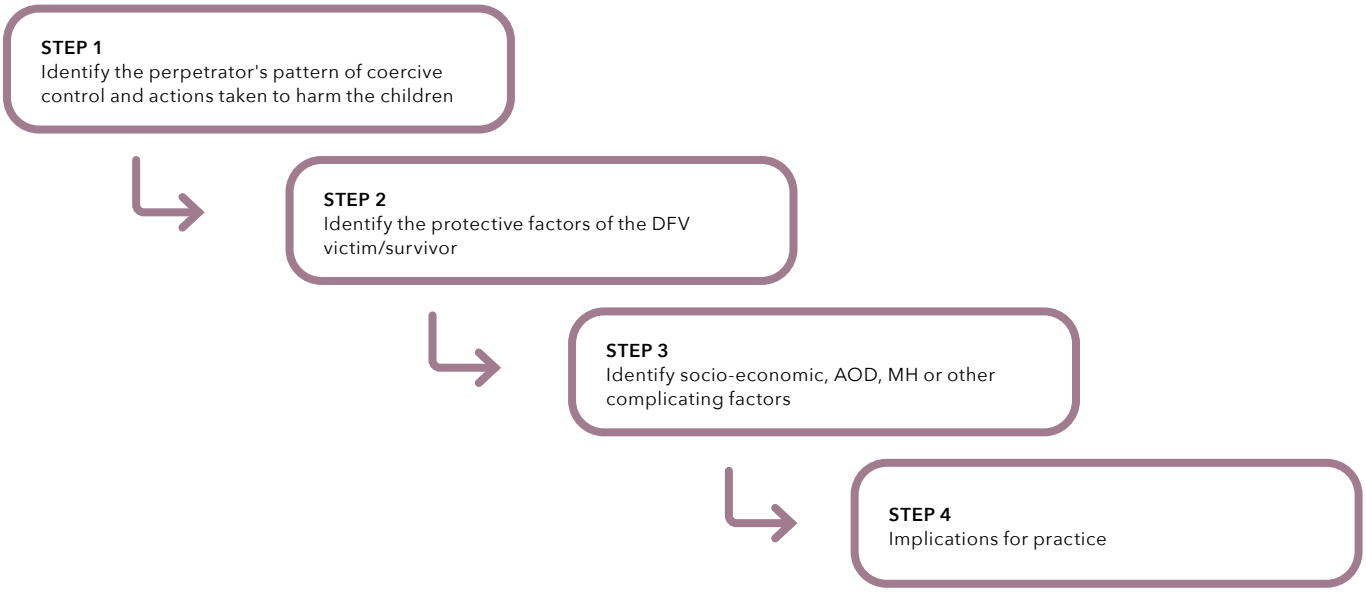


Figure 4: Safe & Together's Mapping Survivors' Protective Capacity Tool



perpetrator". "Pivoting" can be supported by the use of the Safe & Together Mapping Perpetrator Patterns Practice Tool. Its five steps are presented in Figure 3. Partnering work is also supported by the Safe & Together Mapping Survivors' Protective Capacity Tool. The four steps of this partnering tool are presented in Figure 4. Pivoting should only be done while keeping children's safety and wellbeing in view and should not be undertaken without "partnering" with the non-offending parent. Pivoting involves consistently keeping a focus on how the perpetrator and his pattern of behaviour impact the children and adult victims/survivors and family functioning. This is done through discussion and questioning of cases, within established systems and ways of working, through documentation and as part of collaboration across programs, services and sectors. The approach to families contrasts with practice that may blame the adult victim/survivor for the violence in the family and which may make the perpetrator of violence invisible. The model therefore represents, in practice and in philosophy, a complex system intervention that is child-focused, ethical, and explicit in its attention to capacity-building worker skill and organisational change towards being more DFV-informed.

The customisation of the model for working with families where there are complex intersecting issues such as AOD and MH in the child protection context, and the provision of a shared language and vision that supports collaborative working across a range of statutory and non-statutory organisations, have been consistently identified across the projects undertaken with the Safe & Together Institute as a primary appeal of the model (Humphreys & Healey, 2017; Healey, Humphreys, et al., 2018). Promising results from evaluations of the Ohio child protective services (Chaney Jones & Steinman, 2014), the work of the Florida Coalition Against Domestic Violence (David Mandel & Associates, 2010), and Queensland's Walking With Dads program (Meyer, Hine, McDermott, & Eggins, 2019) highlight this issue.

In the preceding STACY project, there was an explicit focus on the critical component of the S&T Model working at the intersection of DFV, MH and AOD. This represented more than a focus on co-occurrence of these issues. Instead it targeted the way in which the perpetrating parent, DFV, and coercive control and abuse were kept in view and impacted on the issues of AOD and MH. In the STACY for Children project, the research team were particularly interested to understand the ways in which children were retained as a focus when adult services (AOD, MH and to a lesser extent DFV specialist services) were involved, and mentioned in relation to the two circled critical components in Figure 2.

1.6 Background: Focusing on children at the intersections of DFV, AOD and MH

The research about children living with DFV is consistent in highlighting the extensive harm to most, but not all, children (Holt et al., 2008). Children may be directly physically or sexually abused in the context of DFV (Kimball, 2016); harmed through the disabling of their mothers, physically and emotionally; and faced with fear and the constant undermining of family functioning through economic abuse and homelessness (Kaspiew et al., 2017). Not all children are harmed in the same way and children live in different contexts of vulnerability and protection and are impacted by age, proximity, and violence and its severity (Stanley, 2011). However, living with DFV is the best predictor of children having other adverse experiences (McGavock & Spratt, 2017), and these have a cumulative deleterious effect on child wellbeing (Oral et al., 2016). While children demonstrate their distress in various ways at different ages and stages of their development, similar child responses have been observed in those living with DFV (Kimball, 2016; McTavish et al., 2016) and children living with a parent's/family member's substance use issues (Kroll & Taylor, 2008). These often long-term impacts on children underline the importance of skilful and nuanced interventions where multiple and complex problems co-occur for their mothers and/or fathers.

The harm to children associated with DFV results in many families coming to the notice of statutory child protection agencies (Humphreys, Healey, & Mandel, 2018). Problems have occurred with the lack of "fit" between domestic violence and the child protection response. Statutory child protection in Australia and elsewhere has not been well designed to respond to both an adult and child victim/survivor, to engage with men, and to work effectively across organisations where there are civil, criminal justice and social support needs (Healey, Humphreys, et al., 2018).

Significant impacts of fathers' violence on children have led to demands for child protection social workers, family service workers and specialist DFV workers to pivot to the perpetrator (Mandel, 2014). This requires workers to re-orientate their practice, which has tended to focus on mothers and their ability to protect their children from violence, and ignore fathers and their impact on children (Nygren, Walsh, Ellingsen, & Christie, 2019; Scourfield, Smail, & Butler, 2015). In doing so, child protection practice does not leverage statutory involvement to assess and work with fathers who use violence (Heward-Belle, Humphreys, Laing, & Toivonen, 2018).

1.6.1 Literature review

A critical interpretive synthesis (CIS) was undertaken as part of the STACY project, and has informed STACY for Children. It identified 40 diverse papers from the research literature that informed practice with families and children at the intersection of DFV and parental issues of AOD and/or

MH. From this review, a research article (Isobe et al., 2020) was developed and published in *Health and Social Care in the Community*. A summary of this article is given below.

A review question was formulated at the outset: how does research into the intersection of DFV with MH and AOD inform practice with children and families? To address this question, CIS methodology (Dixon-Woods et al., 2006) was adopted, based on a pilot stage using scoping review methodology (Arksey & O'Malley, 2005). Both these methodologies use structured search strategies to identify relevant literature. While scoping reviews examine the quality of evidence and draw descriptive conclusions from the literature as a whole, a CIS focuses on the relevance of each paper to the research question and uses this critical lens to question the literature and problematise gaps, contradictions and constructions of issues.

In the initial stages of the scoping review process, the authors found that the conventional, aggregative techniques and aims of the methodology were not appropriate for the complex topic under investigation, risking a problematic simplification of practice and of the families living at the intersection of DFV, AOD and MH. CIS methodology has previously been utilised in examining similarly complex areas of research and practice, such as child sexual abuse (McGibbon, Humphreys, & Hamilton, 2015). It enabled the researchers to synthesise and critically engage with the research literature while drawing on rigorous conventions of a scoping review methodology. (For a full outline of the processes and CIS methodology used, see Isobe et al. [2020].)

Three overarching, mutually informative areas emerged from the literature. These were differences in theoretical approaches and client focus; complexity of systems collaboration; and practices converging on mothers. Through these, a synthesising construct was developed to inform practice with children and families living with DFV, AOD and MH issues: *strengthening intersection between DFV, AOD and MH sectors.* These areas and their contributions to the synthesising concept are summarised below, with attention to how they relate to the current project.

1.6.1.1 Differences in theoretical approach

Across the literature, differences in theoretical approach and focus primarily related to whether approaches to client provision were gendered or de-gendered, and whether practice was adult- or child-focused. Historically, adult-focused approaches have seen DFV, AOD and MH issues as separate, resulting in siloed practice across sectors. It is only recently that children and issues of their protection have emerged as priorities for practice within these sectors (Holly & Horvath, 2012). AOD and MH sectors that work with adults were seen to often lack a gendered understanding of their clients. Women's symptoms of abuse such as anxiety, depression and suicidality (Humphreys & Thiara, 2003) were often examined through medical diagnostic models (Rose et al., 2011) that did not take into account ongoing impacts of DFV. Addiction and harm reduction in the AOD sector remained the prominent focus (Tsantefski, Humphreys, & Jackson, 2014), often lacking consideration of gendered factors that influence the viability of treatment towards recovery (Macy, Renz, & Pelino, 2013). There was, however, emerging evidence of client voices being brought forward to inform these areas (Galvani, 2015; Templeton, Velleman, Hardy, & Boon, 2009), and calls for more nuanced and attentive practice that is cognisant of DFV histories, and their gendered impacts, particularly in relation to children's safety (Sidebotham & Retzer, 2018).

Approaches that took into account the gendered nature of DFV, and the impact it has on AOD and MH issues, were predominantly adult-focused, and often included the need to acknowledge and shift problematic attitudes and beliefs when working with women experiencing DFV (Welland & Ribner, 2010). There was some promising practice that situated women as mothers as well as DFV victims/survivors with AOD and MH issues, seen in programs supporting mothers with substance use (Tsantefski, Jackson, & Humphreys, 2015), maternal mental health, and amelioration of the mother–child bond in the context of DFV (Connelly, Baker-Ericzen, Hazen, Landsverk, & Horwits, 2010; Howell et al., 2015; Rizo, Wretman, Macy, Guo, & Ermentrout, 2018; Taft et al., 2011; Zlotnick, Capezza, & Parker, 2011). Recognition of men as fathers, and as fathers who have used violence and abuse against their partners and children, is emerging (Frederico, Jackson, & Dwyer, 2014). Programs that address the intersection of

DFV and AOD use (Stover, 2013; Stover, Carlson, & Patel, 2017; Stover & Kiselica, 2015) and emerging frameworks for working therapeutically in this space (Laracuente, 2017) indicated a shift towards a more gendered approach, although this was much less established than that taken with mothers.

These approaches were often one-dimensional in terms of their ability to take into account and address the complexity of parental DFV, AOD and MH issues for children (Blythe, Heffernan, & Walters, 2010). Risks to children's safety were often the catalyst for a family engaging with services, however there was a distinct lack of engagement with the children themselves (Templeton et al., 2009) and problematic gender bias in engagement with mothers and fathers that situated family members at odds with each other (Frederico et al., 2014). This particularly applied to mothers and their children. As services' focus on risks to children increased, attention to mothers' needs and wellbeing diminished, and monitoring and assessment of their parenting capacity escalated through service engagement requirements (Frederico et al., 2014; Radcliffe & Gilchrist, 2016; Sidebotham & Retzer, 2018; Tsantefski et al., 2015). Children's wellbeing was often linked to their mother's MH where there was DFV (Connelly et al., 2010; Holden, McKenzie, Pruitt, Aaron, & Hall, 2012; Howarth et al., 2016; Loeffen et al., 2017; Perera, Short, & Fernbacher, 2014; Prosman, Lo Fo Wong, & Lagro-Janssen, 2014; Zlotnick et al., 2011), with mothers in some cases held responsible for help-seeking (Loeffen et al., 2017), and little attention was given to how both the adult and child victims/survivors might be impacted by the perpetrator of DFV as the common variable (Sullivan, 2007).

1.6.1.2 The complexity of cross-sector collaboration

For services working in the DFV, AOD and MH sectors, collaboration and work across systems was seen as complex and in need of better integration and mutual understanding of how DFV, AOD and MH interact as a "toxic trio" (Radcliffe & Gilchrist, 2016, p. 133) co-occurring in the lives of children and families (Frederico et al., 2014; Stover, Meadows, & Kaufman, 2009; Tsantefski et al., 2014). With DFV heralded as the "next frontier" for AOD and MH services (Holly & Horvath, 2012, p. 65), practitioners, clients and researchers called for stronger collaborative relationships and diverse strategies to combat the challenges of siloed sectors (Blythe et al., 2010; Coates, 2017; Frederico et al., 2014; Lalayants, 2013; Macy & Goodbourn, 2012; Macy et al., 2013; Stover et al., 2009; Tsantefski et al., 2014; Webber, McCree, & Angeli, 2013).

Face-to-face meetings, training and networking between agencies across sectors and from different backgrounds were consistently identified as good practice that facilitated relationship-building, mutual understanding and preparedness to work with different client groups (Blythe et al., 2010; Darlington, Feeney, & Rixon, 2005; Holly & Horvath, 2012; Radcliffe & Gilchrist, 2016; Sidebotham & Retzer, 2018). The importance of co-convened case planning meetings and the lack of consistency in this area was noted particularly in relation to working with fathers (Tsantefski, et al., 2014), and identified as insufficient in cases where DFV, AOD and MH were prominent factors contributing to child deaths (Frederico et al., 2014). Informal links and strong leadership championing collaborative working (Holly & Horvath, 2012; Lalayants, 2013) were seen as particularly important when moving through practice changes, as were role clarity (Coates, 2017; Darlington et al., 2005), protocols and formalised procedures in maintaining these changes and relationships (Lalayants, 2013; Webber et al., 2013). With a few exceptions (Laracuente, 2017), most of these aspects of collaborative working were discussed in relation to working with women, with less focus on men and children.

1.6.1.3 Practice focused on mothers

Convergence of practice on mothers was evident in the theoretical approaches and complexities of collaboration across DFV, AOD and MH sectors. This is particularly evident in the focus on mothers and their MH in the context of DFV, linked to their children's outcomes (Connelly et al., 2010; Hegarty et al., 2013; Holden et al., 2012; Howarth et al., 2016; Howell et al., 2015; Loeffen et al., 2017; Perera et al., 2014; Prosman et al., 2014; Rizo et al., 2018; Taft et al., 2011; Zlotnick et al., 2011). In contrast, interventions and programs that involved men as fathers and perpetrators of violence were much less prominent, and were mostly concerned with DFV and AOD (Hashimoto, Radcliffe, & Gilchrist, 2018; Laracuente, 2017; Radcliffe & Gilchrist, 2016; Stover, 2013; Stover et al., 2017; Stover & Kiselica, 2015; Welland & Ribner, 2010). With one exception (Laracuente, 2017), these were not

directly linked with outcomes for children. Laracuente (2017, p. 384) provides a stark assessment: "This maternal focus in IPV intervention, although useful and necessary, reinforces victim blaming and leaves partner-abusive fathers free from taking responsibility."

In the context of these converging practices, fears of being disbelieved, increased violence from perpetrators, and above all child removal impact parents' (particularly mothers') disclosure of circumstances involving DFV, AOD and MH and engagement with services (Ghaffar, Manby, & Race, 2012; Hashimoto et al., 2018; Loeffen et al., 2017; Macy et al., 2013; Rose et al., 2011; Tsantefski et al., 2014). These fears impacted significantly on mothers' help-seeking, even when this represented women's best efforts to keep their children safe (Tsantefski et al., 2015).

1.6.1.4 Strengthening the intersections of DFV, AOD and MH

Strengthening the intersections of DFV, AOD and MH emerged as the synthesising concept across the major themes in the literature, and pointed towards ways of improving problematic practices and embedding positive changes. A disturbing trend consistently identified in the literature is the focus on women's mental health without consideration of their experiences of DFV (Humphreys & Thiara, 2003; Sidebotham & Retzer, 2018). Meaningful practice change is unlikely to occur unless MH services and child protection organisations move their attention from mother-blaming to the perpetrator of violence as the source of risk.

The isolating tactics associated with DFV are compounded at the level of the service system, in how it situates family members and their individual issues in relation to each other. Without collaborative practice between DFV, AOD and MH sectors, these tactics cannot be effectively addressed, and will jeopardise the safety of the service system response. Consideration should be given to whether the service system replicates abusive tactics or provides an appropriate response to safety and wellbeing for women and child victims/survivors (Charles, 2011; Heward-Belle et al., 2018; Isobe et al., 2020).

The constant challenge to provide a safer and more effective response to DFV applies not only to the specialist DFV sectors and child protection, but also to MH and AOD services that may be the first places where both perpetrators of violence and abuse and victims/survivors come to the notice of the system. Acknowledging the gendered dynamics of DFV and service systems' response to this issue, and strengthening awareness and capacity across sectors to work with all affected family members (including fathers who use violence), emerged as critical. There needs to be an increasing focus on the way DFV and parental AOD and MH issues impact children that does not simply name the risk factor. This will include genuine attention to and engagement with the voices of young people themselves. Without strong collaborative practice that takes into account the gendered, intersecting nature of these issues, circumstances for children and families living with DFV, AOD use and MH issues will not improve.

CHAPTER 2:

Study 1: Listening to the voices of people working and living at the intersections of DFV, AOD and MH

Data collected from several sources during the STACY project were re-analysed for this study through the lens of children's needs and perspectives, providing further context to the analysis of the implementation of the S&T approach to child protection in the context of DFV and parental AOD and/or MH issues. In particular, this child-focused analysis provides further depth to the practitioner perspectives of working with families' intersecting complexities and thus the needs of children and young people, in order to address the following research questions.

2.1 Research questions

1. How do individual family members experience the interventions they receive when they are clients of an organisation that is implementing the S&T Model when working with children and families living with DFV and where there are parental issues of MH and/or AOD?
2. How have practitioners experienced the implementation of the collaborative S&T Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

2.2 Structure and sites

The STACY project was conducted across three states in Australia in 2018–19, and involved an academic research team; consultants from the Safe & Together Institute; project advisory groups (PAGs) in each state (senior managers or CEOs of participating organisations, and peak body representatives in Victoria); practitioners involved in the communities of practice (CoPs) convened in Victoria, New South Wales and Queensland; other practitioners mentored by the CoP workers; and children, mothers and fathers who were clients at the participating organisations (Healey et al., 2020). As mentioned above, STACY for Children drew on data collected at these sites.

2.3 Methodology

A mixed methods research design provides the framework for the project. The mixed methodology of qualitative and quantitative data drawn from several sources has been found to be most useful when researching the area of violence against women (Sullivan, 2007), both from practitioner perspectives (Healey, Humphreys, et al., 2018) and that of clients—DFV victims/survivors and perpetrators alike (Heward-Belle, 2015; Lamb, Humphreys, & Hegarty, 2018).

Collectively, the following data sources from the STACY project were re-analysed and used to triangulate collection and analysis for the current project:

- notes from CoP workshops at each state research site
- qualitative data drawn from a survey of practitioners participating in CoP workshops and as "secondary participants"
- quantitative data drawn from the DFV-informed continuum of practice exercise
- case study component:
    - interviews with practitioners from organisations participating in the STACY research
    - interviews with clients (children and young people, mothers and fathers) of organisations participating in the STACY project. Additional interviews with two clients (young person and mother) were also conducted specifically for this project.

A more detailed description of each data collection methodology follows.

2.3.1 An action research framework

The STACY project was underpinned by a practitioner-led (co-design or action research) framework (Cook & Wagenaar, 2012; Evans & Terrey, 2016; Ison, 2008). This is a combined strategy for inquiry (research and learning) and development (practice and action) that involves movement through iterative cycles of reflection and review to enable simultaneous contribution to evidence-gathering and practice change (Ison, 2008).

The challenges facing practitioners in managing the complexity of the intersections between DFV and parental issues of MH and AOD—while maintaining a focus on the needs of the children from their perspective as well as from that

of the non-offending parent—were analysed in the data. Maintaining a DFV focus means keeping the adult and child victims/survivors safe while intervening effectively with the perpetrator of violence and coercive control. Strategies identified by practitioners to address the challenges in working collaboratively across the services were also documented. At the same time, a process of continuous reflection about what approaches work and why was undertaken and recorded.

2.3.2 Communities of practice (CoPs)

The STACY project involved practitioner participants meeting regularly from November 2018 to July 2019 to receive three days of training in the S&T Model and participate in a series of six CoP workshops in each of the three participating state sites (New South Wales, Queensland and Victoria). Practitioner participants were senior staff working in statutory child protection agencies, specialist DFV services, NGO family services, AOD services and MH services.

In each state, local members of the research team (with one of the S&T consultants) facilitated a CoP. One CoP was facilitated each in Queensland and Victoria respectively, involving up to 30 participants in each state. In New South Wales, two evenly sized CoPs involving a total of 30 participants were facilitated.

Each CoP workshop had a theme—two of which were specifically about keeping children in view—and consisted of de-identified case discussions that focused on the process and outcomes of applying the S&T Model in practice. These discussions, facilitated by the research team, involved case practice with families where there were parental issues of AOD and MH in the context of DFV, in relation to the meeting's theme. An hour-long cycle of questions, discussion, coaching and reflection, led by the S&T consultant, followed the case presentations. Members of the research team audio-recorded and took detailed notes of the de-identified cases presented. Following the ethnographic technique of participant observation (Madden, 2017), this drew together the learning attained through the involvement of participants from diverse disciplinary and sector backgrounds in the training and workshops and the practice context that practitioners brought to their discussions in the workshops.

These data (as with all qualitative data collected) were identified and coded into themes, and have been re-analysed with a child focus for the purposes of this current study.

During the CoP phase, participants invited colleagues or staff they had regular contact with to become secondary participants in the project. The CoP participants engaged with secondary participants as agents of change to pass on learnings and work towards embedding DFV-informed practice. Figure 5 illustrates the range of service areas to which CoP participants and secondary participants belonged (as indicated by the STACY project questionnaire responses).[2] While CoP participants' change agent work could be broad, involving presentations and briefings to large numbers of practitioners or senior staff across organisations and partnerships, they were expected to work with a small number of practitioners or senior staff by introducing them to the S&T Model and thereby influencing their work according to its principles. Most secondary participants who responded to a question about their level of involvement indicated that they had been offered up to three sessions with a CoP participant. These secondary participants did not attend the CoPs but were invited to take part in the S&T e-learning modules and to complete the questionnaire and the continuum of practice exercise.

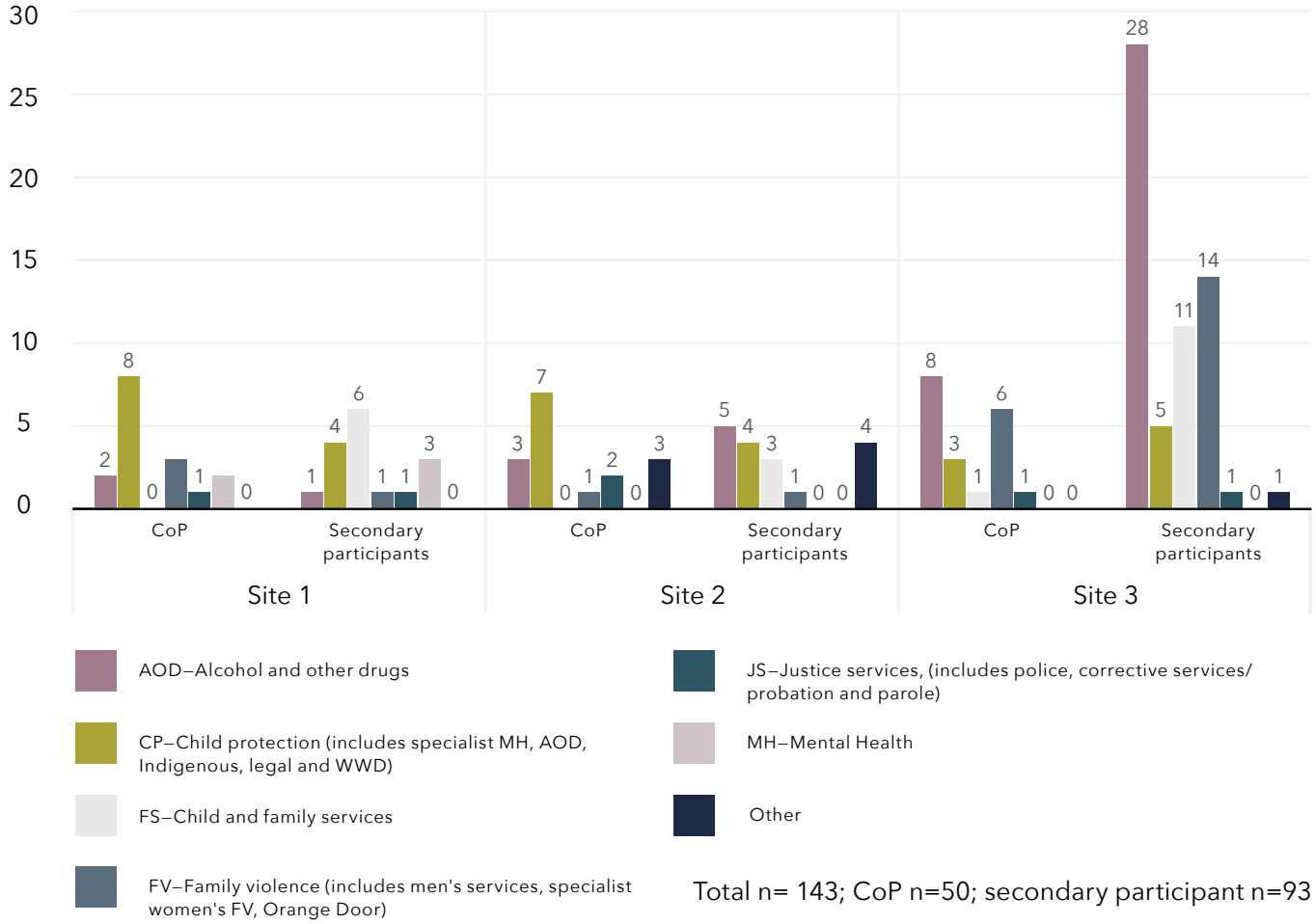
2.3.3 The case study component

The case study component involved the re-analysis of 21 one-to-one, semi-structured interviews with clients, and with 28 practitioners who had provided (or were providing) interventions to clients in five organisational research sites across the three state sites. Data from two additional original interviews with clients were also analysed as part of the case study component.

Interviews are non-experimental in research design and are more common and useful for qualitative research in complex areas, such as DFV and child protection issues, where it is not possible to isolate and manipulate a single variable. The interview data provide qualitative information about how services were operating and how they were experienced, and

2 See section 2.3.4 for further information about the STACY questionnaire, including response rate.

Figure 5: CoP and secondary participant service areas by site



have been combined to develop composite stories, examples or case studies that are included in this report.

Interviews were sought with mothers, fathers (the perpetrating parent) and young people aged 9–18, who were receiving an intervention from staff of a participating organisation, were known by practitioners to have engaged positively with the organisation, and were not in immediate crisis. Perpetrating parents were only eligible if abiding by existing intervention or parenting court orders and keeping agreements with the organisation not to engage in harmful behaviours toward family members.

Qualitative data collected in the STACY project from interviews with 12 mothers, five fathers (the perpetrating parent) and four young people aged 9–18 were re-analysed. In addition, data collected from an additional interview with one mother and one young person were analysed. All client data were obtained from people who were receiving an intervention from staff of a participating organisation in the STACY or STACY for Children projects, were known by practitioners to have engaged positively with the organisation, and were not in immediate crisis. Perpetrating parents were only eligible if abiding by existing intervention or parenting court orders and keeping agreements with the organisation not to engage in harmful behaviours toward family members.

Practitioners approached potential interviewees in the first instance, to explain the research and ascertain eligibility and interest. This step enabled practitioners to assess eligibility criteria (following a researcher-designed checklist) to ensure that no clients were invited to participate who could not do so safely. Contact details were then provided to the researchers, who then contacted the eligible participant to obtain consent and arrange an interview. For young people, practitioners first obtained consent from a young person's parent and then approached the young person as already outlined. Interviews were conducted face to face with mothers and by phone with fathers. Young people were able to choose either option.

Strict protocols were developed by the research team to address ethical concerns and ensure the anonymity and safety of client interviewees and their families (see section 2.4). Interviews conducted as part of this component are presented in Table 1.

Table 1: Interviews conducted as part of the case study component

Interviewees	Site 1	Site 2	Site 3	Total
Mothers	6	5	2	13
Fathers	-	4	1	5
Young people	3	1	1	5
Practitioners	2	8	18	28
Total	11	18	22	51

Interviews were audio-recorded where consent was given, and notes were also taken by the researcher during the interview.

2.3.4 Online questionnaire

Data from three open-ended questions from the STACY project questionnaire were re-analysed using a child lens for the study. Within the frame of working with children and families living with DFV and parental MH and AOD issues, these questions focused on areas of good practice, areas for improvement and how practice can become more child-focused. The questionnaire was programmed into Survey Monkey and hosted online for participants to complete electronically. CoP and secondary participants in all sites were asked to complete the questionnaire as part of their involvement with the STACY project between 6 August, 2019 and 9 September, 2019. Of the 379 participants invited to complete the questionnaire, 50 of the possible 87 CoP members and 93 of the possible 292 secondary participants provided responses. The response rate for CoP members was 57 percent, and for secondary participants 32 percent, with an overall response rate of 38 percent. Secondary analysis was conducted only on those questions which were relevant to the research questions of the current study (see Appendix B).

2.3.5 Domestic violence-informed continuum of practice exercise

During the CoP phase of the STACY project, the research team drew on the S&T domestic violence-informed continuum of practice, and learning from the Invisible Practices project, to create a tool for participants. This tool involved a matrix with four dimensions of practice assessed along a simple numeric rating of 1 to 5, with 1 representing the least developed implementation of an all-of-family way of working and 5 representing the most developed stage. This numeric rating therefore replaced the S&T-devised scale moving from destructive practice to proficient practice (see Appendix A).

The continuum exercise was administered as a reflective exercise where CoP participants rated their personal practice and that of their organisation at the beginning of the STACY project and at the end of the CoP phase. The purpose of this exercise was to explore where participants perceived changes in their own practice, or that of their organisation, and contributed to the project's overall exploration of capacity-building practice change at the intersections of DFV, AOD and MH. Two of the four dimensions or scales that participants were asked to rate are relevant to child-focused practice. They are:

Scale A	*About the adults*	⟷	*Integrated with children/other CP issues*
Scale B	*Child versus adult survivor*	⟷	*Child safety and wellbeing tied to adult survivor*

2.3.6 Data analysis

Data from the CoP discussions, the case study interviews, and selected questions from the online questionnaire were analysed following the techniques of qualitative thematic analysis as described by Braun and Clark (2006). This form of thematic analysis involves an inductive coding process assisted by NVivo (Version 12) software, with "nodes" being generated iteratively through multiple readings of each transcript, relevant research and academic literature, and other data collected as part of the broader STACY project. Patterns of ideas or actions were located in the dataset and brought together into meaningful groups. For the purposes of this current study, secondary analysis with a child focus was conducted by the same team of researchers, again using qualitative thematic analysis. Each component of data was analysed by one researcher. Simple descriptive and cross-tabulation analyses of the continuum data were conducted.

2.4 Ethics

The research was authorised through four ethics applications, approved in all participating states:

- University of Melbourne HREC ID 1852605.2 (title: The STACY project: Safe and Together Addressing ComplexitY)
- University of Melbourne HREC ID 1954087.2 (title: Safe & Together: An all-of-family approach to practice)
- University of Sydney HREC ID 29019/189 (title: Evaluation of the Jannawi Family Centre)
- Queensland Government's Hospital and Health Service (Metro North) HREC/18/QPCH/46628.

CoP participants were requested, as part of the action research methodology, to adhere to the principles of confidentiality, cooperation and mutual respect, in order to facilitate an environment in which it was safe to discuss challenging professional practices and relationships with each other's agencies. Comments that participants wished to keep confidential were not recorded in the notes. To protect confidentiality, individuals and agencies have not been named, and any identifying details have been disguised.

For the case study component, a range of strategies was implemented through eligibility, recruitment and interview processes to ensure the safety of all participants. Eligibility screening was conducted by both practitioners and researchers to guarantee a realistic assessment of possible risks. This also ensured that interviewed fathers were not related to mothers and young people who were interviewed, and care was taken that perpetrating fathers were not aware that their children or partners were participating in interviews.

For young people, parental consent was sought before they were approached. Screening also involved a careful assessment of their maturity and level of understanding to ensure their assent was informed, and that they understood the importance for their safety and wellbeing of not disclosing their involvement in an interview, other than to their mother and key worker.

To ensure the safety of victims/survivors, they were contacted by researchers using the method they had identified as safe, and were interviewed at a safe location of their choice, during daylight hours. Both adult and child victims/survivors were given the option of having a "most trusted person" in the room during the interview.

Given the small number of clients interviewed, great care has been taken to disguise or omit any identifying details, such as names, circumstances, events and turns of phrase, in analysis and reporting. Professional identities are also protected: practitioners are only indicated by the type of work or program they are engaged in. In some cases, workers were interviewed together; quotes drawn from these interviews are attributed to the overall group and identified by the combination of workers who participated.

2.5 Findings: Listening to the voices of people working and living at the intersections of DFV, AOD and MH

The findings presented in this section are a result of a child-focused re-analysis of several data sources collected through the STACY project that relate to interventions for children and families living with intersecting issues of DFV, MH and AOD. These findings relate to the following research questions: how do family members experience the interventions they receive, and how have practitioners experienced the implementation of the S&T Model when providing interventions? These questions are responded to in the light of the impact of parents' complex lives on children and the difficulty of working at the intersections of DFV, AOD concerns and/or MH concerns.

The section starts with an examination of interviews with clients and practitioners, as well as further insights from practitioners collected from CoP notes and the online questionnaire. These include the perceptions of family members who received services from workers who had participated in the STACY project and insights from the practitioners themselves. The latter had participated in training and coaching in the S&T Model. Practitioners from a range of service types were interviewed, including child protection

(CP), AOD, and specialist family violence services for men and for women. No MH practitioners were interviewed.

Three main themes emerged from the interviews with clients and with practitioners:

- the visibility of children within adult-focused services
- addressing children's individual needs
- child-focused practice at the intersections.

All practitioners whose roles or views are presented within a client's narrative were involved in implementing the S&T Model, even if they were not directly involved in the STACY project's CoPs (for example, they may have been STACY secondary participants or otherwise exposed to S&T training). Many interviewees made comparisons between previous experiences of service provision and their work with S&T trained workers, indicating that the latter was much more helpful. However, the interview transcripts did not always provide sufficient information for researchers to ascertain whether all good practice described related to service provision informed by the S&T Model, particularly as many practitioners worked within organisations that engaged in high-quality violence- and trauma-informed practice prior to their involvement with the STACY project.

2.5.1 The visibility of child victims/survivors in service provision

Practice that renders children visible may include engaging fathers about the impact of their behaviour on their relationships with their children; assessment of the impact on parenting of DFV, AOD or MH issues; and direct engagement with children about their experiences. Data drawn from both family member interviews and consultations with professionals indicate that the practice of S&T-trained workers showed an increasing recognition of the importance of assessing children, parenting and family functioning in any DFV intervention. However, throughout the data, keeping a direct focus on children was given less attention by practitioners than engagement with fathers or partnering with mothers.

2.5.1.1 Clients' voices

Parents who had been clients of services highlighted a range of ways that practitioners had engaged in assessing their parenting and the functioning of their families. Many reported talking about their children with practitioners and being referred to specific services, such as parenting education groups, family support services or men's behaviour change programs (MBCPs).

Mothers in particular highlighted how elements of the S&T approach used by their workers had contributed to an increased understanding of the perpetrator's pattern of abusive behaviour and its pathway to harming children. This included children's victimisation and experiences of abuse, effects on family functioning, and effects on the non-offending partner's parenting. One mother reported that the use of S&T tools enhanced the effectiveness of her practitioner in addressing the impacts of DFV, as well as helping her to better understand the tactics of coercive control to which she had been subjected:

> Making the perpetrator mapping with [practitioner]… was confronting but really helped me understand his strategy and how it was affecting the children and myself. (I-S3-M-01)

This was contrasted with other, less positive experiences of services, particularly services with practitioners who had not trained in the S&T approach. Some mothers described feeling that their parenting was unfairly and disproportionately scrutinised while fathers were held to lower standards. Mothers also described some practitioners who failed to consider DFV when assessing parenting:

> I had the caseworker saying you know, like she was trying to get me to do parenting courses and I just said I don't need to do parenting courses. (I-S2-M-04)

The case example of Tim (see boxed text) highlights another gap in assessment, where the AOD service failed to consider the safety of the mother and children when allowing Tim to disengage without informing other services working with him. We do not have access to the perspectives of Tim's partner and children on the impact of his behaviour or on the effectiveness of the services he was engaged with.

Tim

The presenting practitioner described Tim as a father who had self-referred to an MBCP and, as part of the initial screening, reported his engagement with an AOD service. Tim wanted to be with his family but felt they needed to accept his excessive drinking (possible alcoholism) and consequent violent and abusive behaviours.

Toward the end of the MBCP, Tim admitted uncontrolled drinking and that his partner was threatening to leave. When the DFV worker said they would contact his AOD worker, he reported that he had disengaged from the service. However, the AOD worker had not communicated this to the MBCP. MBCP staff were concerned that Tim did not consider the children as a part of his life and that he was not taking responsibility for his drinking or for the allied abusive and controlling behaviours towards his partner and children. While he owned his drinking and controlling behaviour toward his partner, Tim said it had been going on for so long (two decades) that he did not know any other way. The practitioner quoted him as saying that this was "their dynamic … so just accept it" (with his partner).

The ensuing discussion in the CoP focused on hypothetical conversations to have with Tim about the impact of his abuse of his partner and the children. Part of this conversation centred on the S&T consultant's suggestion that all practitioners involved with him, whether AOD or DFV, needed to be talking about his children. If Tim is staying in the relationship for his family, when he is abusive and drinking he needs to connect the interrelated impacts of these behaviours on his children. In other words, "the children are the one way in" to reach that part of Tim that might begin to think about changing. (CoP#6-S1-DFV)

Another factor in increasing the visibility of children was engagement with the whole family to increase the safety of women and children, including interventions with men who use violence and control. A high level of interagency communication and information-sharing was similarly important in ensuring that services had an accurate picture of children's circumstances. One mother described her disappointment when an MBCP facilitator contacted her to report their belief that her ex-partner had taken accountability for his violence. This contact was very important because it enabled her to challenge this view and to report that he was still being verbally and emotionally abusive to his children during contact visits:

> I go well, no, because you know it's an act … you know you're not taking full accountability for things, because why was it escalating with the children, if there's still denial of anything you've done wrong to the children. (I-S3-M-02)

Many of the fathers who participated in interviews reported that their involvement with services was instigated by either a court or a statutory child protection agency. Across the three sites, there was an increase in the number of father-specific MBCPs in operation and an increase in the willingness of all-of-family services to engage with men who use violence and control. This demonstrates a significant shift in practice towards workers assessing parenting when engaging with perpetrators of DFV and seeing violence towards women and children as a parenting choice.

Fathers engaged in one particular all-of-family service described how this service identified themselves as focused on children. Some fathers, however, believed that their parenting was not an issue and criticised their partner's parenting. Other fathers were able to see the impact of their violence on children and reported their commitment to changing their parenting for their children.

GOOD PRACTICE

In good practice, perpetrators of violence are being helped to understand that the use of violence and control is a parenting choice. Working with fathers to explore the relationship between their AOD and MH issues and DFV and the impact of this on parenting behaviours and relationships with their children is encouraging motivation for change; this, in turn, is being used in goal setting and case planning. A father explains:

> I'm the key person in my family okay, and same as my wife, what I had done caused a consequence, which is very serious to me and to my wife, to my son. We almost lose our son, you know, it's so serious to our life. So, what I think, well, not just saying, this is my fault, I have to change my behaviour. (I-S2-F-03)

2.5.1.2 Practitioners' perspectives

Like family member interviewees, many practitioners were positive about the role of the S&T Model in helping to promote a deeper understanding of how children are affected by DFV. For example, CP practitioners reported that the S&T Model is helpful in shifting assessment and intervention from a focus on the mother's actions, particularly the notion of "failing to protect" her children, to the father's patterns of behaviour and their impact, both on the children and on the mother's mental health, substance use and ability to parent. A child protection worker explained:

> In my old days it would be, "She's [child's mother] got a mental health problem, she's got an alcohol problem" … therefore I would say, "Well, you're the person who needs to sort this out". Within that would be also, "While you're at it, can you sort out your mental health problems and your alcohol problem", without doing the analysis, doing the assessment. (I-S1-CP-01)

Interviewees described the model being used by CP practitioners to influence how adult-focused services understand and work with their clients. For example, the perpetrator mapping tool (see Figure 3) is being utilised to demonstrate the impact of the perpetrator's behaviour on the mother's mental health and substance use to professionals working exclusively with adults.

Some practitioners from the AOD sector were already familiar with considering children's needs as a motivating factor in parents seeking treatment. The case example of Tim (see earlier boxed text) demonstrates the challenges faced by professionals from all sectors in helping men find a reason to make difficult changes in their lives. Interviews suggested an increasing awareness that children are also powerful incentives for fathers to address their use of violence, a concern that can be used therapeutically:

> Coming from the space of their child is a safer space for them to begin with, where they feel more comfortable talking about this … "I love my child, I want what's best for them" … In turn, we see the change happen in them, and we see them actually start to reflect on themselves. (I-S3-AOD-17_AOD-18)

Improvements in assessment by the AOD sector were noticed by other professional groups. A DFV worker commented:

> I think where before they [AOD services] weren't sort of picking up a lot of stuff, now they are … so there's definitely greater understanding. (I-S3-DFV-02)

While practitioners from AOD services reported an organisational commitment to focusing on children's wellbeing and safety, many saw their main function as providing services

GOOD PRACTICE

Experiences of violence and coercive control can profoundly affect women's use of AOD, MH and ability to parent effectively. When this relationship is not understood, professional intervention can be limited to the symptoms of abuse, rather than the cause, or result in inappropriate interventions focused on the mother. A child protection worker explains how she and a colleague assisted a psychiatrist to see a patient's situation through a domestic violence-informed lens:

> We went over there and spoke with a psychiatrist and the psychiatrist was focusing on the drugs and the mental health and we said, "No, no, you need to focus on the domestic violence perpetrator". (I-S1-CP-02)

to adult clients. Practitioners reflected in one CoP that the S&T Model is a poor fit for non-CP settings and equates to trying to fit the client's story into the model. Relationships and children can be used as motivating factors in substance counselling, but "that isn't the majority of our clientele". Children can't always be the main focus, for example where a father who comes for substance counselling is "disenfranchised from his child" (CoP#3-S1-AOD).

In addition, the ability to work therapeutically with parents was reported to be challenging when child protection concerns were identified:

> There's always been a bit of a concern about, I guess, not wanting to shut those clients out who are coming for AOD support, but then saying, "You've given us this information, we have to take this to Child Protection". It's trying to find a way to work safely around that, and make sure those parents are still going to engage with us for ongoing contact and support, in spite of that. (I-S3-AOD-17_AOD-18)

In some services, policies and protocols were seen to directly inhibit practitioners' ability to implement a more DFV-informed, child-focused practice, particularly in relation to perpetrators' behaviours and their impacts on children. As one MH practitioner recounted:

> … our ability to engage the perpetrator on his behaviour. It's the most significant concern in the family. However, due to our policy we cannot interact with it. It's like having a giant elephant in the room that no one can directly address. By not being able to directly address the behaviours I feel it can grow in the shadows. (Q-S2-MH-CoP-9)

In adult-focused services such as AOD or MH, asking adult clients at the outset of their involvement whether they were parents was proposed by questionnaire respondents as a basic first step in increasing the visibility of children.

> … to ensure from the outset (e.g. intake processes) that we are asking clients if they have children, and if so, asking about [what effect] parental mental health and/or substance use in the context of DFV is having on them. (Q-S3-FS-Infl-28)

Such questions allow children to become visible in adult-focused services where DFV and its impacts might not be core business. Questionnaire respondents believed that many practitioners are not yet aware of this, and also acknowledged the need for ongoing work in this area, albeit within services' limitations and parameters. The following questionnaire responses, from an AOD worker and an MH worker respectively, illustrate that some shifts have been made through exposure to the S&T Model, but that change across these sectors is in its infancy.

> There is certainly a space for clinicians who have done S&T training to voice concerns/advocate for children/explore the impacts of substance use and violence on children at the point of treatment planning, i.e. in clinical review meetings. This is certainly happening more since STACY but there is a way to go. (Q-S3-AOD-CoP-10)

> While our organisation has a long way to go, our executive team is committed to improving the way we respond to DFV and child protection matters. DFV has not previously been seen as core business. However, our service as a whole is becoming more aware of the complex interplay between DFV and MH issues … Children are often "invisible" within the adult mental health service. Bringing children to the fore as part of routine screening and ongoing rolling assessments will help identify support needs for parents and help to promote the safety and wellbeing of children. (Q-S1-MH-CoP-89)

A shift in focus was also noted by practitioners from women's DFV services. A recent review of one service's risk assessment framework identified comparatively little focus on children, and changes were made to better reflect not only women's, but also children's, lives in the risk assessment framework and internal database.

In their questionnaire responses, practitioners described the S&T Model as providing a key shift in thinking that enabled engagement with perpetrators even when they were not present. Documenting specific facts, details of the violence and its impact on the family unit, and creation of appropriate links with other services were put forward by many as key strategies. This increased focus on the perpetrator's pattern of behaviour, a key component of the S&T Model, is being reflected in risk assessment. This has allowed a deeper

understanding of the impact on children and children's needs.

> By focusing [on] and identifying perpetrator behaviours we have a better understanding of the impact this has on family functioning, victims and their children. Focusing on how his behaviours impact on the children and pivoting back to the perpetrator. This assists with understanding how his behaviour impacts on the victim's mental health and substance use where assistance can be provided for victims and have better outcomes for children. (Q-S1-CP-CoP-68)

This information is being used therapeutically with fathers:

> We're asking questions about children's contact with the perpetrators, the relationship to the child, questions about support e.g. significant adults; also questions as to whether the dad is disrupting the child's attendance at school or access to friends and family. Also, more questions relating to dad's impact on the child's mental health and what harm he's causing, exacerbating, interfering with. So, we ask many more questions about the tactics of perpetrators' patterns of behaviour and harm to the children. (I-S3-DFV-01)

The increased attention to children is also reflected in men's DFV services. A DFV worker described drawing attention to DFV as a fathering choice:

> We worked a lot with dads where they feel justified by abusing their partner, spitting in her face, calling her degrading names and things like that, but when you start to reframe it, where were the kids? What was the impact on the kids? What was your child doing when it happened … When you bring the child into the room and you bring it back to a parenting choice, you get a different response from fathers. (I-S3-DFV-03_DFV-04_DFV-05)

Asking direct questions about children—in screening and assessment of mothers and fathers but also throughout cases and service delivery—was cited by questionnaire respondents as a key learning from the S&T Model, promoting a child-focused, DFV-informed approach to practice. Practitioners proposed questions about the impact of violence, AOD and MH on parenting, and the implications of this for children and their relationships with their parents. Many questionnaire respondents described how questioning of this type needed to be directed to both mothers and fathers, in order to hold both parents responsible for children's needs and wellbeing. Framing DFV as a parenting choice was a particularly salient shift for practitioners as they implemented the S&T Model in their practice, further explored below in relation to constructions of children as survivors.

> Workers can draw out, through assessment and case management phases, the impacts of violent behaviour on children. This is often discussed with men. However, it can be common for blame to be shifted to mothers/non-offenders. Workers can develop further skill in really bringing out how children have been impacted. (Q-S3-FV-CoP-30)
>
> … by making it part of routine practice to ask about the welfare of the children during our assessments, planning or reviews. By having more educational sessions that focus on children but also take into account the limitations of the services a client may be accessing. By using language that makes both parents responsible for meeting the needs of the children, as opposed to just making only the mother responsible and having low expectations for dad. (Q-S2-AOD-CoP-106)

Other suggestions for child-focused work in holistic practice involved ensuring that children's perspectives are considered whether or not direct engagement is possible.

> Ensure that practitioners consider their client-parents' presentation from the children's perspectives. (Q-S3-AOD-Infl-52)
>
> … assessments focusing on the perceptions and timelines from the children's perspectives, in addition to the perceptions of each adult in the home. (Q-S2-CP-CoP-34)

Other practitioners engaged directly with children. For example, one DFV practitioner interviewee explained how she engages directly with children in office-based settings, schools or family homes:

> I went out to see mum. I had a chat with the child while I was there. Then, later on, throughout the involvement, towards the end, she wanted to come in and see me with her dad. She said, "Dad, can you stay out here", and he said, "Yes, no worries". So, he waited out there and she

> spoke to me in there, just to let me know how things were going. (I-S3-DFV-02)

Some interviewees stated that more emphasis is still needed on "bringing back the voice of the child and not getting caught up in what's the current crisis for the parent". Variability in workers' awareness of, and capacity for, direct engagement with children was noted:

> Some workers are much more comfortable doing that sort of stuff with kids and others are really only comfortable working with parents and struggle to do stuff with kids. (I-S3-AOD-17_AOD-18)

One specific agency employs workers to speak with colleagues about prioritising children's needs, as well as a child and family team who aim to influence the practice of other teams across the organisation through secondary consultations. These developments were described as "a big culture shift", away from the traditional approach of "working with one person, or an individualist kind of view". They have resulted in "more eyes on the family and more work being done, rather than just that one job". This change in practice was "a learning curve for a lot of clinicians, already, around recognising their responsibilities for safety and for children, and, actually, how to do that work safely with parents".

2.5.1.3 Tips from practitioners: Visibility of children within adult-focused services

In good practice at the intersection of CP, DFV, MH and AOD, children are clearly visible to all service providers. By focusing on children's experiences, services can help to ensure their safety and wellbeing, increase perpetrators' motivation for change and partner with women as mothers. Children's visibility can be promoted and maintained in a number of ways, both directly and indirectly, depending on whether the service engages with children or not. Attention to children needs to occur at the levels of the individual worker, the team, the organisation and inter-organisationally. Strategies for ensuring and maintaining the visibility of the child in service provision can include some or all of the following:

- As a matter of routine, ask all clients about their parenting status, for example: are they parents; do they have children in their care; do they have access to their own or their partner's children?
- Ensure organisational risk assessment frameworks include attention to children's needs.
- Help perpetrators understand that their use of violence and control is a parenting choice and explore the relationship between their AOD use, MH, DFV and their parenting behaviours and relationship with their children. Use this information to encourage motivation for change, set goals and devise treatment and other case plans.
- Together with the mother, map the perpetrator's pattern of behaviour to help her understand the tactics of coercive control and how it affects the children and the family's functioning, including her AOD use, MH and ability to parent her children effectively. Share this information with other service providers.
- Where possible, engage directly with children to seek their perspectives. Use the information they provide to inform assessment and case planning.
- Ask mothers about any changes in the perpetrator's behaviour and include this information in assessments about their own and their children's safety and wellbeing.
- When collaborating with other services, ensure there is effective communication about children's experiences, circumstances and needs.
- Inform other service providers when perpetrators disengage from services and supports, and remember to mention whether perpetrators have access to children.

2.5.2 Seeing children's individual needs

Asking the questions necessary to understand children's experiences of DFV where problems with parental MH and AOD use also occur is crucial to implementing the S&T Model. This means hearing and acting on children's and young people's voices. This can be done through direct and age-appropriate engagement, or through asking questions of parents and professionals to understand each child as a unique person with an individual perspective on what has happened to them, and developing appropriate service planning for each child.

2.5.2.1 Clients' voices

Data from family member interviews illustrate changes in the way that children's individual needs were seen by service providers. Of particular interest was how the S&T Model might increase practitioner proficiency in DFV-informed practice with children. Promisingly, many family members reported feeling that workers constructed children as unique victims/survivors with individualised needs from services.

Seeing children as survivors precipitated efforts to engage, interview and validate them. Family members described ways that practitioners made visible the impact of violence and control on children within the family. One mother described the importance of her son having his own counsellor, as he may not feel able to talk to his parents as openly about his experiences. Parents also described their children's engagement with a child-focused, all-of-family service:

> My son sometimes comes see [practitioner] too … before when the [statutory child protection] come and make trouble or my family, my children, my son never talk with anyone. But slowly, slowly, I bring him here with me. (I-S2-M-03)

> They have a very good place for children to play and they have a playground and they have all the facilities to support kids. (I-S2-F-03)

Although there was extensive indication of positive shifts towards seeing children's individual needs, there were also clear tensions brought about by changing practices. While most services describe themselves as "child-centred" or "child-focused", services were often seen to focus primarily on adults, thereby marginalising children's experiences and perspectives. Of particular concern was that this included child protection services, whose work by its very nature should be highly focused on children and their experiences.

Several of the parents interviewed discussed their involvement with a children's service but did not provide any information regarding how their children were directly engaged, instead focusing on how services engaged with adults in the family. Several of the children interviewed did not recall many details about their child protection practitioners. The limits of engagement of children is illustrated in the following excerpt:

> [Interviewer:] And the [child protection agency], were there any conversations with the kids present? Or anyone talking to the kids about what was happening?
>
> [Mother:] No. Not in our situation. They had their private chats with the kids. But anything about what happened, kept to the adults. (I-S1-M-06)

Families raised concerns about the seeming lack of consultation with children about decisions that significantly affected their lives. Common concerns were separation of siblings in care placements, children having ongoing contact with violent perpetrators, and the restriction of contact between children and their mothers. Of particular relevance was children's perceptions of their lack of power in court proceedings, where it is essential to consult them about decisions. One young person reported particularly negative experiences with legal practitioners, stating that his lawyer didn't make significant efforts to meet with him and instead made assumptions about his preferences for placement without consultation:

> Out of the whole year, I got to see my lawyer once … and they just said that, that the assumption of my lawyer was just, I wanted to go back to live with my dad, which was right … but he never consulted me before that. (I-S2-YP-01)

Many family members were concerned that the impact of DFV on children, risk of further abuse and intersection with AOD and MH issues were not adequately addressed. One mother who was interviewed discussed her recent experiences with the child protection system as a young person herself:

> I was on drugs, like heavy drugs … nobody really cared. Nobody really cared about me or how I was or what I was doing. It could have been too late. (I-S1-M-05)

Several family members also believed that services had ignored or inadequately investigated children's disclosures of violence. Several mothers in particular raised concerns regarding the way in which allegations of sexual abuse towards their children had been managed. Many felt that their children had not been listened to, nor adequately protected from further abuse.

Many family members also reported their perception that numerous practitioners were deficit-focused when it came

to their approach to children. A deficit-focused approach constructs children's responses to trauma as problematic, or pathological. This approach stands in opposition to trauma-informed and domestic violence-informed approaches that see children's responses as adaptive. Several family members raised examples of services focusing on children's delayed development, school non-attendance or problematic behaviours. One mother described receiving complaints about her children being noisy and jumping on beds within a DFV refuge. One father described having complaints from his son's childcare around his biting other children and his lack of social skills. Family members reported that young people were most frequently pathologised by workers. They described services focusing on older children's mental health problems, substance use and use of technology. These issues were commonly constructed as indicative of issues originating within the individual child, rather than as responses to living with the oppression and uncertainty of DFV, trauma, parental AOD and MH issues, and other adverse childhood experiences.

However, family members also provided examples of practitioners focusing on children's resilience and strengths. Examples included workers commenting on their children's high levels of attendance at school and high degree of engagement with services, and the development of strategies aiming to increase safety, resilience and protective capacity within families. One mother highlighted the complexities of her children being violent towards her, and how services helped her to contextualise this as a response to the child's ongoing exposure to the perpetration patterns of their father:

> When [service] spoke to the kids they could tell them that it was normal to feel hurt and it was normal to feel angry and want to express that, and that it was normal … and that there's ways of you know dealing with that, the kids were making up their own ways … (I-S2-M-04)

The final tension in how children's needs were articulated can be seen in representations of the mother–child relationship. One of the key aims of the S&T Model is to challenge mother-blaming practices and recognise the interdependence of women's and children's safety. Family members highlighted how services working from this perspective aimed to prevent children's separation from mothers and supported children to be safe at home with their family:

> As soon as [practitioner] said to me that you know, "You've done so well, we're bringing the kids home", I could not literally stop crying. (I-S1-M-04)
>
> They asked me about what happened with me and my ex-husband and I ah, I was lying too, not lying, I hid the truth because I was scared … she told me that [child protection agency] told us about everything and no worries, you can talk and no one will take your son. (I-S2-M-02).

However, there was also evidence of the entrenched nature of the "failure to protect" discourse, by which mothers are blamed for their partner's DFV and harm to children. Janelle's story (see boxed text) illustrates this dynamic, where the assessing worker did not look further than the mother's presentation for the source of risk. There is no record of the children being consulted. All of the mothers interviewed reported a prevalent fear that involvement with services for DFV could lead to the removal of their children by statutory child protection workers. Mothers who had experienced the removal of a child often described the distress, trauma and shame this caused for them:

> I had one caseworker from here I didn't like … she literally blamed me for everything that [children's father] did to me, and that I caused all the fights, and it was my fault. (I-S1-M-04)
>
> They said, "Well if you're with him, you are not going to get your kid back". (I-S1-M-05)

Mothers also described the punitive or threatening nature of service responses. They identified how partners would control and coerce them by threatening to call child protection services or manipulate systems by making vexatious allegations about them, and that practitioners could at times be complicit. Services were also described as at times reproducing dynamics of coercive power and control towards mothers, including through "using" children:

> I was not allowed to see the kids on Christmas day, 'cause they were afraid that [their father] would turn up. (I-S1-M-04)
>
> The youth liaison officer at the police station was really abusive to me as well, he, I had a phone conversation with him where he said, "You know if you stay, I'm going … I'm prepared to go to court to say that you're the abuser". (I-S2-M-04)

Janelle

The responder to a CP notification identified MH issues in a mother, removed her children and placed them with their father. The mother was considered confrontational. She was frustrated with CP not holding the father to account for 15 years of violence against her. She had never reported it because she didn't want people knowing her business. She had separated from her partner 12 months before and had a psychiatric (psychosocial) breakdown. When CP stepped in, she had a moment of breakdown, went to the father's house, was arrested by the police and taken to hospital for an MH assessment. No MH issues were identified. The mother had used cannabis following the separation.

The children were returned to the mother under clear guidelines with a parenting agreement in court about where the children go and when. The practitioner talked about counselling to the mother as she felt disempowered and cheated. She was in the system as causing harm but the father had never been called to account. "We know now he plays mind games, threatens to pick the children up from school and not bring them back if she didn't give him money, so she had stopped taking them to school." (CoP#3-S1-CP)

Some mothers also felt services could have offered more support prior to the children's removal, or intervened further with men who use violence and control by holding them to a higher standard and engaging in efforts to make men who use violence responsible for their abuse.

2.5.2.2 Practitioners' perspectives

Child protection services and family services tend to describe themselves as child-focused and see children as unique people with needs separate to those of their parents: "It's always been about what's happening for the children and hearing the voice of the child … even if you're working with absent fathers, what's happening for the child?" (I-S3-FS-15)

Similarly, DFV and AOD practitioners reported that their services are striving to see children, to hear their voices and to intervene early to improve children's outcomes. A DFV worker drew attention to the need to see children as individuals with unique experiences: "I've only seen the children together, but if there's a need to see them separately, I can't see the reason why not." (I-S3-FS-16)

In their questionnaire responses, practitioners described this as moving away from viewing children as merely witnesses who are "exposed" to DFV, towards conceptions of them as individuals affected by perpetrators' behaviours and patterns in unique ways.

> For me, framing DFV as a parenting choice has allowed me to ask questions and open up conversations in a different way. This moves away from children being harmed due to "exposure" and frames the behaviour for what it is—targeted and destructive to children. I think if all practitioners and clinicians change this mindset we will all become more child-focused when discussing DFV with both perpetrators and survivors. (Q-S2-Other-CoP-18)

> … workers having a rich understanding of the various ways children are impacted by DFV—moving away from the limited idea that children are only affected if they witness physical abuse. (Q-S3-AOD-CoP-44)

Practitioners highlighted the importance of age-appropriate engagement with children. Suggestions included play therapy to engage younger children, offering transport to a playgroup, running playgroups in a public park (I-S2-FS-01) and specialised services that could respond to adolescents and their complex needs.

GOOD PRACTICE

In child-focused practice at the intersections of DFV, MH & AOD, each child is seen as an individual, and children's voices are heard and responded to. A number of age-appropriate strategies are being conducted with children of all ages, from infants through to toddlers, in a range of settings and approaches. These include playgroups for younger children and counselling sessions for adolescents, either individually, together with their mothers or in sibling groups. A family services worker outlines a response to the complex needs of adolescents:

> We also have strong risk assessments in place for children and an emphasis on the child as client in their own right and assessing and supporting them with their own particular needs … developing stronger, more appropriate response to young people aged between 16–18 who often don't fit nicely into support service criteria but need a specialised approach. (Q-S3-FV-CoP-114)

Questionnaire respondents also drew attention to the need to include children, in an appropriate way, and engage directly with them.

> We need to put the children's voices in the decision-making process. (Q-S2-AOD-Infl-14)

> … having the voice of the child clear at the centre. Keeping children informed in an age-appropriate way about the progress of the case and what supports and risks are accessed. (Q-S3-FV-Infl-26)

> Children are clients in their own right and they have a right to be heard. Children need to be encouraged to speak their mind and to talk about what happened to them, they need to know that their experience is valid and it matters. Case managers are encouraged to interact with children and spend time with them during crisis/refuge entry and to talk to them about the services and their rights as clients in the service. (Q-S3-FV-CoP-27)

A worker from an MBCP also drew attention to the rarity of consultation with children as experts in the DFV dynamics of their family:

> When I first sort of saw her with her mum, she was saying things like, "Dad used to be really mean to my mum, that was, until you came along" … We don't ask kids to rate it now and rate it later, it's just that natural conversation of how things are going. (I-S3-DFV-02)

In the interviews, two areas of work were mentioned as important in child-focused work: school advocacy and documentation.

Several interviewees reflected on the role of schools as potential supports for children, and easily accessed venues for interviews with children in the absence of their parents. Two specialist DFV workers mentioned speaking with children at school: one, accompanied by a family services worker, spoke directly with children, while the other recounted encouraging child protection workers to interview children at school. However, interviews with practitioners across the spectrum of services highlighted that without a domestic violence-informed lens, schools can hold mothers solely responsible for children's attendance and wellbeing. A child protection worker recounted:

> [The] Education [Department] were going to prosecute the mother for the child not going to school … but we've now had a conversation with Education about that, giving them the mapping so they can see the impact of his [the father's] behaviours on the mum and child and why that child is not going to school. They were saying we have to hold the mother accountable and we were saying no you need to hold him accountable for the child not going to school. (I-S1-CP-02)

Family services and AOD treatment services are similarly working with school principals and teachers to help them understand the dynamics of DFV. Interviews with practitioners suggest that a unified message about DFV is being delivered to schools. An AOD worker commented:

> The referral might say parenting support or child non-engagement with education … It's bad behaviour at school; it's not trauma-informed behaviour at school that they're exhibiting for a number of reasons. So, we're doing a lot of education with the schools to say, "This family has literally been sitting in a war zone and now you're expecting them to be calm in the classroom". (I-S3-AOD-12_FS-13_FS-14)

When they are DFV-informed, schools are able to provide children with appropriate support. A family services worker contrasted the child clients' current and previous schools:

> We've got a psychologist at school. Because they attend a community school, they've got extra support there … whereas the school they were at previously wouldn't let us have meetings without dad, or we had to fight for that … they just get really caught up in what they feel that their requirements are, that they have to let both parents know, is where they're coming from, but we're saying, actually, it's kind of really unsafe. (I-S3-FS-16)

A number of practitioners referred to the importance of strengths-based and accurate documentation as another way of addressing children's needs in the present and the future. For example, the importance of documentation was mentioned by a DFV worker in relation to children having a truthful account of events:

> You get the kids say, "I've got to tell the story again? Why don't you read the bloody file?" And, then, I say, "Okay, I'll read the file but it says this and this and that's not right". (I-S3-DFV-08_DFV-09)

Across all sectors, having an accurate history spares children and young people from having to unnecessarily recall painful memories. Another DFV worker commented:

> She was also aware that, yes, I've read the file and I'm aware of what happened to her as a baby, we didn't have to talk about it … so, she was really happy to spend time with me on a one-to-one basis and just talk about what was going on for her, and just talk about whatever she wanted to talk about. So, that was really important for her. (I-S3-DFV-03_DFV-04_DFV-05)

The S&T perpetrator mapping tool was mentioned by a number of practitioner interviewees, in terms of its usefulness in understanding the impact of DFV on children and young people, and as a means of hearing their voices. Practitioners talked about using the tool to help young people understand their own experiences and the impact of their own violent behaviour on siblings.

Adolescents who engage in violent behaviours were seen to be in need of services and supports in their own right. A family services worker's comments highlight the tension in practice: "Mum obviously can't protect the other siblings, but then, that child still deserves safety as well." (I-S3-FS-16)

Although there were several comments highlighting the value of perpetrator mapping as a vital tool for documenting patterns of abuse and the experiences of different family members, one specialist AOD worker in a family services agency noted that its use is still largely dependent on individual workers and is therefore not as widely practised as it could be: "I know for years we've been talking about the children's voice and having children's voice in documentation but it's not really there yet, and it depends on individuals' practice." (I-S3-DFV-08_DFV-09)

This quote also indicates that, despite the widespread recognition among practitioners that working with and including children's voices is essential, and their confidence that this is happening, in many cases this has not translated to child-focused practice.

Even in services specifically set up to work with children within the context of families, children can remain invisible, with attention directed solely towards mothers. A family services worker described the lack of attention to, or engagement with, children:

GOOD PRACTICE

Trauma- and domestic violence-informed approaches are helping to contextualise children's behaviours as adaptive responses to adverse experiences. Workers are mapping perpetrators' patterns of behaviour to help children understand not only how they have been impacted by DFV, but also how their own violent behaviour affects other family members, including mothers and siblings. A DFV worker recounts the utility of the approach:

> We've done it with adolescents who have been kind of the victims … as well about the impact they're having on their siblings. They've been abusing their parent, but the impact they're having for their siblings to see it, because they can't see past, they don't really care about mum at the moment, but this one in particular, she couldn't get over how much her little brother was looking at her and that's what really got to her, was how much she scared her little brother. (I-S3-DFV-03_DFV-04_DFV-05)

> She's very empathic, she's a lovely worker and she gets it [DFV] but I'm not sure she knows what to do with it. So, she hasn't met with the kids. She hasn't talked with these kids, even though she's been with mum for six months at least. (I-S2-FS-02)

Children's needs are sometimes recognised by professionals, but without sufficient attention paid to individual children and their specific experiences and challenges. For example, a DFV worker described a mother trying to cope with her children's challenging behaviours and support their recovery, while being simultaneously blamed for their non-attendance at appointments:

> The child struggles with control and any perception of being told what to do, how to feel, how to react, it is a big trigger to the pressure on mum and that acknowledgement, you know. She's working in her own therapeutic way with the child, encouraging them to attend things, but in doing that, you've also got to allow the child's own will in the process of saying, "Well, I'm not going today. I don't feel like I want to go today." So, then, that would be flipped back on mum, "You're not getting the child to appointments", and then the systems responses to that would be, "Well, we need to make a report because you're denying the child access to mental health". (I-S3-DFV-08_DFV-09)

To effectively address children's needs, practitioners emphasised the need to be aware of what services were available in their areas for children. Establishing and strengthening interagency relationships that offer effective support and handover of cases was key. However, the availability of DFV-informed MH services for children and young people who have experienced DFV was described by interviewees as a "service gap". A DFV worker pointed out the complexity of needs at the intersections of DFV and MH.

> You've got kids who are aggressive and violent towards each other, towards mum, they've got mental health issues, they've got, there's a family violence history … They needed our service, they needed an adolescent violence service, they needed mental health services and just to make sure that everything was going okay; they still needed to keep in touch with an old counsellor that they would touch base with every so often. (I-S3-DFV-08_DFV-09)

Where adolescent MH services are available, they are not always DFV-informed. Zac's story (see boxed text) illustrates the difficulties of working at these intersections when the authorising environment is weak or absent, services take a siloed approach to intervention and a there is a lack of recognition of the degree to which DFV and MH issues are interrelated. In a similar situation to Zac's, a DFV worker described having to explain the relationship between a child's MH problems and domestic violence to hospital staff and advocating for the child's treatment to be extended:

> He was ordered in a hospital, like a psych service, but then they have their own timelines of having to discharge him within three days, and then he was going back into a relationship with mum, but mum's impacted from the family violence and responds to him in a certain way … I'm going to the hospital and saying, "This is the history; this is the violence that happened; this is the dynamic between him and his mum, you can't just discharge him", but they did. (I-S3-DFV-08_DFV-09)

Some interviewees noted that even workers well-informed about the impact of DFV on children had problems keeping the child in mind in the context of a child-blind organisational culture and the ability of many fathers to direct attention away from their own behaviour. One father made complaints about gender bias in the organisation and the lack of focus on father's rights. In the process the children's voices were lost:

> Then you lose sight of the child, amongst all of that, because it gets wrapped around by the bureaucracy and people's views, in the meantime you have children or a child there, and that's when children get lost, it's when those sorts of things happen and we see it all the time, it just overrides that. (CoP#5-S3-DFV)

Zac

Zac, a 15-year-old boy, has been a mental health patient in a hospital setting for five months, working on issues such as depression. His mother has been hospitalised twice due to violence from his father and his younger sister, has left with her children and is with a new partner. Zac's mother and her new partner now have three children under 3 years of age. Zac's father committed suicide on Zac's birthday. Outreach with the family revealed potential environmental issues for Zac and that his mother struggles with parenting and spends significant time in bed.

Following S&T training, the worker realised that there was an "invisible parent": Zac's stepfather. He has a previous intervention order (IVO) for violence against Zac's mother, was removed from the family and completed a men's behaviour change program. In exploring with Zac his relationship with his stepfather, the relationship between mother and stepfather and the boy's perception of any financial coercion, Zac reported that his mother sometimes "inspires" his stepfather to hit her, but that he is otherwise just lazy. The worker would like to assess family dynamics more deeply, and engage with the stepfather, but the organisational culture opposes stepping into what was seen as family violence sector work.

The ensuing discussion in the CoP focused on how the worker could advocate for further exploration of the family context, through drawing on trauma-informed frameworks to show the violence as a source of ongoing mental health issues and a risk of repeat engagement with services. Zac is at risk of adopting abusive behaviours and internalisation of negative attitudes that are already manifesting in his response to his stepfather's abuse of Zac's mother. The worker was therefore advised to tailor the organisational response to Zac's significant adverse childhood experiences in order to protect against detrimental development, rather than focusing on the ongoing DFV. (CoP#1-S3-MH)

2.5.2.3 Tips from practitioners: Seeing and addressing children's individual needs

Child-focused practice at the intersection of DFV, MH and AOD requires that service providers see each child as an individual, that they hear children and young people's voices and that they respond in a manner commensurate with each child or young person's development and needs. Addressing children and young people's individual needs can be achieved in the following ways:

- See children as clients in their own right, directly engage with them, validate their experiences and provide them with age-appropriate information.
- Use age-appropriate strategies and settings for engaging with children of all ages in work with families. Some examples include in playgroups, in child-friendly counselling rooms, in sessions with mothers and children together, or with children as a sibling group.
- Consult with children on matters of significance in their lives, such as whether they wish to have contact with perpetrators of violence, other family members or significant others, and those with whom they live, including siblings.
- Listen to children's disclosures of violence and/or maltreatment and take protective measures to ensure their safety and wellbeing.
- Practise from trauma- and domestic violence-informed approaches. These contextualise children's behaviours as adaptive responses to their experiences, normalise children's responses, and explain to them and to others how their behaviours are reactions to adverse experiences.
- Focus on children's resilience and strengths, such as school attendance, engagement with services and the deployment of strategies to increase safety.
- Support children's relationships with their mothers and aim to prevent unnecessary separation of mothers and children.
- Be mindful of how perpetrators of violence can manipulate service systems and children to extend their use of violence and control, such as through vexatious reports to child protection services or threats to remove children from school.
- Hold fathers to the same high level of parenting as that expected of mothers.
- Support the use of a DFV lens across services, including children's schools, to reduce mother-blaming, for example by not holding mothers solely responsible for children's attendance.
- Ensure that all documentation, including case notes and court reports, is written from a strengths-based perspective and portrays an accurate account of events—this spares children having to recount and correct painful events.
- Map the perpetrator's pattern of behaviour with children to help them understand their experiences and the impact of their own behaviour on others, including siblings.
- Maintain a comprehensive list of services for children and make referrals, as appropriate.

2.5.3 Child-focused practice at the intersections

Thus far we have described the insights of family members and of practitioners into the experiences of child-focused service provision informed by the S&T Model in relation to children and families living with DFV and where there are parental issues of MH and/or AOD. Promising practice has been noted where children are not only visible to practitioners, but are also seen as individuals in their own right, with unique experiences and needs. Problematic practice, deficits and service gaps have also been discussed. In this section, we focus on what family members and practitioners had to say about the elements of effective child-centred and child-focused practice in this area. As highlighted by the S&T Model, this involved partnering with mothers, intervening with perpetrators, and supporting the safety and wellbeing of children. Also highlighted were examples of sustaining system-wide change.

2.5.3.1 Clients' voices

Family member interviews highlighted many examples of good, child-centred practice with families living with DFV where there were additional complexities of parental AOD and/or MH issues. Examples of effective practice with mothers to keep children safe were highlighted in a number of interviews. Key components included not holding victims/survivors responsible for violence, holding perpetrators accountable, responding to the unique needs of the family and providing holistic support to promote women's safety and recovery. Another important aspect of a positive service response involved keeping children safe at home with the non-offending parent, a key goal of the S&T Model.

Mothers in particular highlighted the need for support with their mental health and substance use issues, which were impacted by the DFV perpetrated by their partners. Mothers described the impact of good practitioners in services in increasing safety and trust:

> She wasn't going to put me down or judge me for it. She made herself like a normal person, you just felt like you were talking to a normal person, not someone who was above you or looking down on you. (I-S1-M-06)

> [Worker's name] always calls me, asks about me and the children … she always helps me with everything. (I-S2-M-02)

Mothers reported positive outcomes from engagement with services who partnered with them, such as increased contact with children, restoration of children, being safe to leave a violent partner and feeling confident to engage in legal proceedings.

Significantly, examples of effective, child-centred engagement with fathers who had perpetrated DFV were highlighted in the interviews with fathers but also with women and children. Some of the fathers highlighted the focus of services on their children and the transparency of practitioners in discussing safety concerns:

> They said to me that yes, mainly we are child services. We are here because of all the reports that we have been hearing about you being negative and violent and that's one of the things we are concerned about, and we want to help you with that. And ah, that's what made me feel more calm. (I-S2-F-01)

Both mothers and fathers discussed how effective services engaged perpetrators to hold them accountable for their use of violence and support positive changes in their parenting:

> [Men's behaviour change program worker] has been working with [partner] for 3 or 4 months now and he is incarcerated at [correctional facility]. But she worked with him once a week I think and she does pretty well. He has come a long way, keeps going, "What's next". (I-S1-M-05)

> My fathering skills are heaps better … more positive … I see that my son respects me more than before. (I-S2-F-01)

Several mothers reported witnessing changes in their partner's behaviour, including a reduction in his use of violence and abuse and an increase in taking responsibility as a father including doing household tasks, daily care of the children, cooking and transporting children to school or appointments. Some mothers and all fathers reported feeling positive about fathers being able to have safe contact with their children, often with the supervision and support of services.

Other aspects of effective service provision identified by parents included flexibility with appointments, the capacity of workers to conduct home visits or meet in the community, the provision of practical support with household items and necessities, and the opportunity to work with the same practitioner over a longer period of time. Capacity to engage the whole family was also consistently highlighted as significant in enhancing service capacity to keep children safe.

Common in young people's experiences of positive intervention for DFV was feeling that practitioners listened to them, respected them and included their perspectives in decision-making. This included decisions about their education, support services and placement or restoration to their families. Furthermore, young people highlighted the importance of practitioners engaging with the whole family to address violence and additional complexities relating to parental substance abuse and mental health: "I like how they are helping out my family, and how they are like helping us be closer and we respect each other more now" (I-S1-YP-01).

Practitioner efforts to support children's recovery, and to include children's voices in case planning and safety planning, were built on their understanding of the dynamics and impacts of DFV. As one of the young people interviewed stated: "We were talking about the situation with [perpetrator] and how I felt about it. And what I wanted to change and stuff like that I think." (I-S1-YP-03)

Children were engaged with statutory and non-statutory child protection agencies, all-of-family services, police and justice services, speech therapy, educational institutions, perinatal services, youth mental health services and supported playgroups. Particularly significant to effective engagement with children was the ability of practitioners to use a range of age-appropriate strategies for consulting with children of all ages, from the perinatal period to adolescents.

One mother described how her 3-year-old son enjoyed coming to the family service, where he could see his own counsellor while she attended her appointments. Another mother described engaging with services during the prenatal period and the ways in which her partner's violence impacted on her pregnancy. At the other end of the age spectrum, one teenage interviewee described how she appreciated workers promoting her sense of autonomy through supporting her goals to enrol in tertiary education and achieve independent accommodation. The worth of providing an age-appropriate space within which children and young people can voice their views was articulately put by Elijah (see boxed text). Elijah commented on the difference between his experiences of interventions from the current agency working with him and previous experiences of practitioners not informed by the S&T Model or an all-of-family approach. Elijah appreciated the direct relationship with his support worker and her including him in decision-making processes.

GOOD PRACTICE

Children report positive interventions when a whole-of-family approach to addressing DFV, AOD and MH is undertaken, when they feel listened to and respected, and when their perspectives are included in decision-making. A young person explains:

> It's the support they give … it's also like they are not the people that are going to force you to do something, that's what I like about [practitioner]. They actually just give you the options. (I-S2-YP-01)

Elijah

Elijah is 14 years old and lives with his father, stepmother and siblings. All are supported by practitioners in an agency that has developed an all-of-family approach and that have been trained in the S&T Model.

His parents separated when Elijah was a young child and, in his words, "do not get along". His mother lives in a nursing home owing to a chronic illness and Elijah sees her once a month when Zoe, his support worker, helps him visit.

Elijah really appreciates the support he gets from the workers because of the way they provide advice, explain his options and respect his autonomy in making decisions. He reported that "they are not the people that are just gonna force you to do something; that's what I like about [agency]." He values the fact that they treat him like a capable person rather than a child and he feels that they have helped him to improve his decision-making.

In comparison to statutory CP interventions, he believes the current agency has improved his family relationships, saying that "they made us a very happy family." He believes the agency has helped improve all of his relationships extending to friends, school and extended family relationships.

He attributes these improvements to the communication style of the workers in "advising you, not telling you". He came to trust Zoe after just three sessions with her because he felt she genuinely cares (after all, she would still get paid even if she didn't care). (I-S2-YP-01)

The final aspect of effective child-centred services identified by family members was ensuring the existence of mechanisms to sustain system-wide change in order to increase safety for women and children. Several participants highlighted the difference between their experiences with current workers who had received S&T training and/or participated in the STACY project, and previous workers who they felt lacked the same level of knowledge and skills around DFV. Key components of effective practice also raised by clients included interagency collaboration and communication, training of practitioners, accessibility of services and cultural safety for families from Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse backgrounds.

2.5.3.2 Practitioners' perspectives

Practitioners highlighted the value of the way the S&T Model provides clinicians with tools that integrate theoretical underpinnings with practice. This was often reflected in perceptions of positive practice change, particularly towards being more DFV-informed, and good practice at the intersections of DFV, AOD and MH.

Good practice at the intersection of DFV, CP, MH and substance use takes many forms, with work conducted with or on behalf of children. Effective practice requires that workers understand the relationship between parental substance use, MH problems and DFV (each of which is not necessarily a linear process of cause and effect); the impact on children; and provision of appropriate support. This complexity is captured in the comments of a family services worker who drew attention to how withdrawal from substances can exacerbate abusive behaviours and needs to be planned for if children are to be kept safe and well.

GOOD PRACTICE

Effective practice takes into account the complexity of the relationship between AOD, MH and DFV, and also its impact on children. A family services worker drew attention to how withdrawal from substances can exacerbate abusive behaviours and needs to be planned for if children are to be kept safe and well:

> We worked through the understanding of patterns in that the violence increased on the comedown, so the cycle within the home that went, "When we get paid, we get high; we get really productive; we're really loving; we clean the house; we do what makes us more of a protective parent and a successful, healthy partner. Then, when we're on the down, we're crying; we're screaming; we're throwing tantrums; we're intimidating the children; we're pushing mum; and we have no money". That just kept, kind of, continuing. So, our planning was around identifying what days, keeping the schools informed, and checking in, in terms of our contact with the family on those days, and the corrections worker as well. (I-S3-FS-16)

Understanding the complexity in presenting concerns through the S&T Model has led to a profound improvement in some workers' practices. Workers compared current with former ways of working, noting their enhanced capacity to identify and respond to children's most pressing needs by directly addressing family violence. A worker from an AOD service commented:

> Well, we used to do bedtime routines and behaviour charts and how can we all sit and have dinner together. Now we're perpetrator mapping and doing safety plans that require spare mobile phones in boxes. (1-S3-AOD-12_FS-13_FS-14)

The contrast was also highlighted by a specialist DFV worker from a family service, who noted that the focus on children's therapeutic needs is likely to produce good outcomes.

> The other way of working would be, "Kids don't go to school, so they have to go to school", rather than looking at, "Well, what's the reason for not going to school? Is there a therapeutic need to work with them?" Rather than saying, "Okay, let's work out a behaviour chart on getting you to school", which misses the whole point around therapeutic need that's underlying that, and if you sort out the underlying issue, I found, generally, the behaviour that's visible will diminish. (I-S3-DFV-08_DFV-09)

Practitioners describe DFV-informed practice being undertaken directly with mothers, with fathers, with children, or together with mothers or fathers and children.

Examples of good practice when implementing a more DFV-informed, child-focused approach highlighted the need to meet clients where they were in their journeys, and tailor service provision to take this into account. This applied particularly to working with mothers, as seen in the example below:

> We have identified that a blanket "no substance abuse" rule for our clients is not realistic. We recently worked with a client who was using ice as a consequence of significant traumas by multiple perpetrators, and rather than simply evicting her and her children due to her drug use, we established an agreement with the client whereby she agreed that to sustain her accommodation with us, she would engage with a drug-recovery day program, and continue to engage with our workers re: trigger management. We also worked effectively in partnership with child protection services regarding this client's recovery journey, and the safety of her and her children. The client's drug use ceased, she sustained her recovery process and managed to retain safe and secure accommodation, free from domestic and family violence. We learnt from this that taking such a case-by-case, flexible approach is invaluable in supporting women and children to recover from domestic and family violence and associated mental health and/or drug and alcohol issues. (Q-S2-FV-CoP-16)

Attention to the ways in which the mother–child relationship might be undermined by perpetrators, including through manipulation and exacerbation of AOD and MH issues, was also emphasised as good practice. Practitioners reported that some services are undertaking combined work with mothers and children with workers assuming different roles, depending on the needs of the family. For example, work might be conducted with the mother and children together and with the children as a sibling group. The perpetrator mapping tool has been described as useful in counselling with mothers and children.

GOOD PRACTICE

Practice is enhanced when attention is drawn to how the mother–child relationship is undermined by DFV and relationship-based reparative work with mothers and children is undertaken. An AOD worker described how mapping a perpetrator's pattern of behaviour helps children understand the impact of DFV on their mother's AOD use, MH and parenting, and reduces mother-blaming:

> So many women … are all tense and you do the sheet with them and their shoulders drop and the tears come and the kids, suddenly, their little jaws drop. You can just see, someone has actually labelled the good [protective actions taken by mother]. I think, for them, they haven't seen it. (I-S3-AOD-12_FS-13_FS-14)

It was noted that adult-focused services, in particular AOD treatment, can establish a therapeutic relationship with an adult client and direct their attention to the impact of violence on children. An AOD worker explained:

> It's opportunity … a window that you have because you have the therapeutic relationship and you are there to be able to say … "This is family violence and this has an impact on your children". (I-S3-AOD-17_AOD-18)

Some examples are cited of fathers being helped to see the impact of their behaviour on mothers and children, and to assume rightful responsibility, which can lead to positive outcomes for children. A family services worker detailed a case:

> We've done a parenting plan with him … it's really helped us to do just a little bit of work with him to then talk to his daughters about the experience where it comes up and how he blames mum in front of them and that's not okay … It's made a huge difference to the girls at school and here and having friends. (I-S2-FS-02)

However, questionnaire responses revealed a lack of attention to the details of how the father–child relationship might be addressed, and this is an area for further investigation and development of good practice.

Practitioners cited a range of ways in which they pay attention to children's voices and needs. A family services worker explained that in her work with children, she aims to help them understand DFV and to reduce the mother-blaming encouraged by fathers:

> If a child comes in to say, "Oh, you know I missed contact" or "I didn't go to contact this time" or "My dad was late so my mum left and it's all my mum's fault" … Okay, but dad knows what time contact is and dad chose not to be there at the time. (I-S2-FS-03)

Practitioners from a range of services talked about striving to engage in relationship-based practice with children and reported that children are eager to speak about their experiences. A women's DFV worker noted that children are "dying to talk about their experiences if they only know someone who is willing to listen". This was considered critical in understanding the impact of violence on children:

> If you just sometimes hear from the mums, they wouldn't be able to tell you the full impact on the kids. (I-S3-DFV-08_DFV-09)
>
> We've got children telling us what's happening in the home. One of the kids told me recently that he was feeling safer in the home because there was less argument, which used to be daily. (I-S3-DFV-06_DFV-07)

Advocacy and practical assistance were also deemed important, alongside direct engagement with children. An AOD worker described the actions she has taken to ensure an adolescent receives mental health treatment:

> He only went because I said, "Okay, I'll speak for you. I'll fill in the gaps for you. I'll fill in your story. I'll drive you there." So, I did that … but without, I think, someone just being there to do those steps, he would have stopped going … There are a lot of service gaps and a lot of services need the client to be able to rock up and go to them, where, in the trauma, sometimes they really can't. (I-S3-DFV-08 _DFV-09)

Like the family members interviewed who stressed the importance of interagency collaboration and communication, ongoing communication and information sharing—particularly with regard to how perpetrator patterns could impact this—was consistently highlighted by practitioners across sectors. Warm referrals between services, particularly for children, were also seen as good practice that enabled positive engagement and outcomes for families and children.

2.5.3.3 Tips from practitioners: Child-focused practice at the intersections

Child-focused practice at the intersection of child protection concerns, DFV, AOD and MH involves partnering with mothers, intervening with perpetrators and supporting the safety and wellbeing of children. This is best achieved when adopted at a systems level, where perpetrators are held accountable for their use of violence, responsive service provision is targeted to the unique needs of each family member, the safety of women and children is supported, and children are kept safe at home with the non-offending parent. Recommendations for child-focused practice strategies include the following:

- Provide support to mothers in a non-judgmental manner that acknowledges the impact of DFV on their AOD use and MH.
- Discuss child safety concerns with fathers as transparently as possible and encourage positive changes in their parenting.
- Make it easier for families, where possible, to access services by being flexible with appointments, conducting home visits or meeting in the community, providing practical assistance and by continuity in the allocated worker.
- Base practice on an understanding of the complexity in the relationship between AOD use, MH and DFV, and its impact on children. This may require additional training.
- Engage with the whole family to address violence and complexities in AOD use and MH. Children report positive interventions when a family-centred approach is adopted, they are listened to and their perspectives are included in decision-making.
- Pay attention to the ways in which the mother–child relationship is undermined by perpetrators of violence, and provide relationship-based reparative work. For example, help to reduce children's mother-blaming by furthering their understanding of the dynamics in DFV, including how it affects their mother's AOD use and MH.
- Provide warm referrals for children and parents to support positive engagement and improve outcomes for families.

2.5.4 DFV-informed continuum of practice exercise

The DFV-informed continuum exercise conducted with the CoP members in each state provided a measure of the perceived practice change resulting from engagement in the STACY project and the Safe & Together Model (see section 2.3.5 for an explanation of this exercise). The findings can be used to increase our understanding of developments in child-focused practice (research question 2). The questionnaire allowed practitioners to differentiate between the ways in which they perceived their personal practice and the practices within their organisation. For reference, the dimensions of practice in each scale were:

Scale A *About the adults* ⟷ *Integrated with children/ other CP issues*

Scale A moves from practice that is all about the adult victim/survivor and their responsibility to protect children from violence, to practice where child protection (welfare) and safety is informed by a clear understanding of domestic violence and its impacts on children and other family issues, such as AOD use and MH.

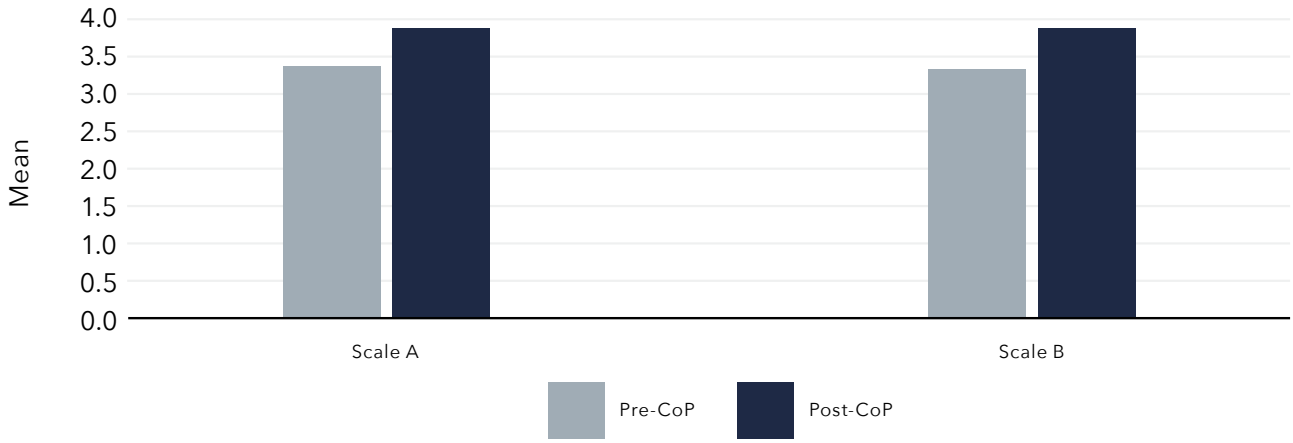
Scale B *Child versus adult survivor* ⟷ *Child safety and wellbeing tied to adult survivor*

Scale B moves from practice that views children's needs and rights as separate and often in opposition to their mothers' to practice in which both adult and child victim/survivor safety and wellbeing are addressed holistically and in the context of one another and their surrounding family functioning.

Practitioners rated their personal and organisational practice along a simple numeric scale of 1 to 5, with 1 representing the least developed implementation of an all-of-family way of working and 5 representing the most developed stage. They completed the exercise at the end of the CoP phase and were asked to provide ratings both for that point in time and for levels of practice before the CoP phase began.

Using the CoP participant ratings, paired sample t-tests were conducted to compare scores on each scale (and therefore measure perceived change on each scale) before the CoPs were run (pre-CoP) and after they had been completed (post-CoP), for both organisational and personal practices. Paired sample t-tests were also conducted to compare overall scores (and therefore the perceived strengths) of organisational and personal practice.

Figure 6: Organisational practice: Before and after the CoP phase



2.5.4.1 Organisational practice

Figure 6 illustrates the change in organisational practice perceived by practitioners. In relation to Scale A (N = 60), there was a significant difference in the organisational practice scores for before the CoPs (M = 3.37, SD = 0.94) and at the end of the CoP phase (M = 3.88, SD = 0.79; t[59] = -6.562, p < .001). For Scale B (N = 59), there was also a significant difference in the organisational practice scores for before the CoPs (M = 3.34, SD = 1.10) and at the end of the CoP phase (M = 3.89, SD = 0.87; t[58] = -6.464, p < .001). It should be noted that the pre-CoP scores represent practitioners' retrospective assessment of their stage of development on each scale. Both pre- and post-CoP scores were collected at the end of the CoP phase.

These results show a perceived improvement during the CoP phase in organisational practice that both promotes an understanding of the effects of DFV on children and supports practice in which child and adult victim/survivor safety and wellbeing are addressed in a holistic context. However, on both scales, overall post-CoP mean scores sit below a rating that would indicate a fully developed implementation of an all-of-family, child-focused approach.

More detail is provided in Table 2 about organisational change in different sectors. While the change was significant in most cases, results should be treated with caution due to small sample sizes. However, several observations can be made. DFV and family services (FS) workers remembered beginning the CoP process with greater levels of confidence in their organisations' competence than workers from other sectors. Organisational practice in FS was seen to have changed the least. Not surprisingly, traditionally adult-focused services for AOD and MH were rated lower to begin with. By the end of the CoP process, AOD and MH services were seen to have improved most in terms of moving towards all-of-family and child-focused practice. The connection between child safety and wellbeing, and that of the adult victim/survivor, appears to have been taken on board by AOD organisations to a striking extent. However, MH organisations were perceived as having made very little change in this area.

2.5.4.2 Personal practice

CoP participants perceived significant changes in their personal practice as well. As shown in Figure 7, overall there was a significant difference in the personal practice scores for before the CoPs (M = 3.68, SD = 0.85) and at the end of the CoP phase (M = 4.30, SD = 0.61; t[60] = -6.73, p < .001) for Scale A (N = 61). Similarly, there was also a significant difference in the organisational practice scores for before the CoPs (M = 3.55, SD = 0.96) and at the end of the CoP phase (M = 4.32, SD = 0.65; t[60] = -8.40, p < .001) for Scale B (N = 61). As noted earlier, both pre- and post-CoP scores were collected at the end of the CoP phase.

Like the results for organisational practice above, the increase in the mean values of scores at the end of the CoP phase shows a perceived improvement in personal practice by the CoP participants. On both scales, post-CoP mean scores sit a little below a rating that would indicate a fully developed implementation of an all-of-family, child-focused approach.

Table 3 illustrates the perceived changes in personal practice by workers from different sectors. Not surprisingly, DFV workers were the most confident in all-of-family, child-focused practice both before and after the CoP process and, perhaps for this reason, indicate the smallest gain compared with practitioners from other sectors. AOD and MH practitioners were least confident in their skills, both before and after the CoP process.

Personal practice change was a little higher for Scale B than for Scale A. In other words, prior to the CoPs, workers across

Table 2: Changes in organisational practice: Pre- and post-CoP

Scale A: About the adults ⟷ Integrated with children/other CP issues						
Mean score (standard deviation)	Total° (N=60)	DFV (n=12)	FS (n=8)	CP (n=19)	AOD (n=11)	MH (n=7)
Pre-CoP	3.37 (0.94)	4.08 (0.82)	3.63 (1.19)	3.26 (0.65)	3.00 (0.77)	2.86 (1.22)
Post-CoP	3.88 (0.79)	4.54 (0.66)	4.00 (1.07)	3.68 (0.56)	3.82 (0.60)	3.57 (0.79)
Change size	*0.51**	*0.50**	*0.26*	*0.42**	*0.92**	*0.77**
Scale B: Child vs adult survivor ⟷ Child safety & wellbeing tied to adult survivor						
Mean score (standard deviation)	Total° (N=59)	DFV (n=12)	FS (n=8)	CP (n=19)	AOD (n=11)	MH (n=7)
Pre-CoP	3.34 (1.10)	4.00 (1.07)	3.50 (1.60)	3.32 (0.95)	2.82 (0.75)	3.00 (1.15)
Post-CoP	3.89 (0.87)	4.54 (0.66)	4.00 (1.20)	3.74 0 (.79)	3.82 (0.60)	3.29 (0.95)
Change size	*0.55**	*0.58**	*0.39**	*0.52**	*1.02**	*0.25*

* Significant: $p < .05$

° Sum of individual sector samples is smaller than the total sample due to the omission of several data pairings that were unclassified by sector.

Figure 7: Personal practice: Before and after the CoP phase

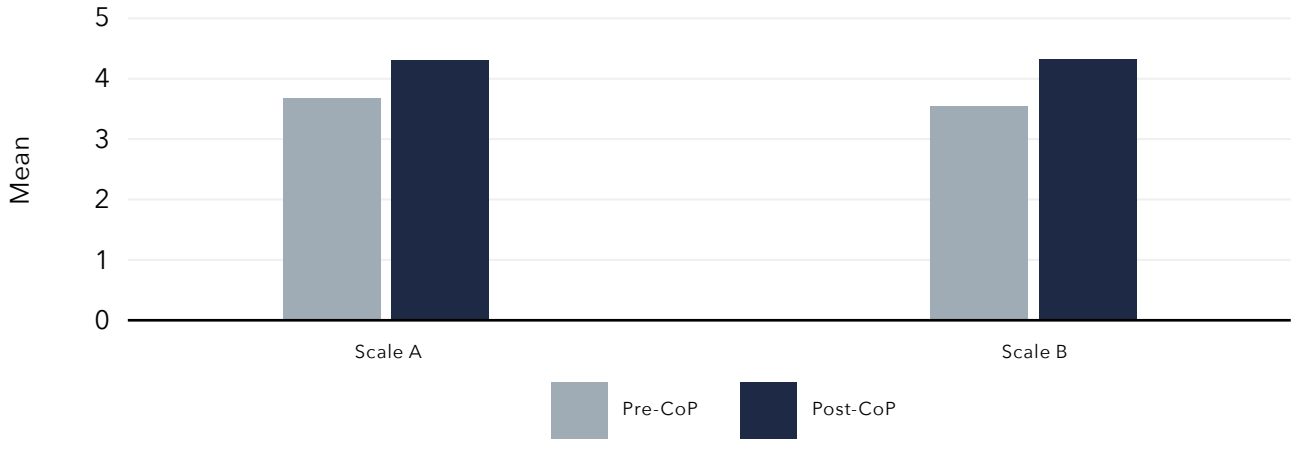


Table 3: Changes in personal practice: Pre- and post-CoP

Scale A: About the adults ⟷ Integrated with children/other CP issues						
Mean score (standard deviation)	Total° (N=61)	DFV (n=13)	FS (n=8)	CP (n=19)	AOD (n=11)	MH (n=7)
Pre-CoP	3.68 (0.85)	4.27 (0.67)	3.50 (1.07)	3.53 (0.70)	3.46 (0.82)	3.43 (0.98)
Post-CoP	4.30 (0.61)	4.62 (0.65)	4.31 (0.70)	4.26 (0.42)	4.09 (0.70)	4.00 (0.58)
Change size	*0.62**	*0.34*	*0.67**	*0.73**	*0.54**	*0.37*
Scale B: Child vs adult survivor ⟷ Child safety & wellbeing tied to adult survivor						
Mean score (standard deviation)	Total° (N=61)	DFV (n=13)	FS (n=8)	CP (n=19)	AOD (n=11)	MH (n=7)
Pre-CoP	*3.55 (0.96)*	*4.35 (0.69)*	*3.50 (1.31)*	*3.47 (0.70)*	*3.00 (0.77)*	*3.29 (1.25)*
Post-CoP	*4.32 (0.65)*	*4.69 (0.63)*	*4.44 0(.73)*	*4.26 (0.48)*	*4.09 (0.70)*	*4.00 (0.82)*
Change size	*0.77**	*0.34**	*0.89*	*0.79**	*1.15**	*0.75*

* Significant: $p < .05$

° Sum of individual sector samples is smaller than the total sample due to the omission of several data pairings that were unclassified by sector.

sectors were more aware of the need to integrate adult and child practice with other child safety issues than they were of the interdependence between the welfare of child and adult victims/survivors. Again, AOD practitioners in particular took this latter concept on board in their practice.

2.5.4.3 Comparing organisational and personal practice

The mean scores set out in Tables 2 and 3 indicate that practitioners were more confident in their personal practice improvement than in greater understanding demonstrated at organisational level.

Pre-CoP personal practice scores were significantly higher than pre-CoP organisational practice scores in relation to Scale A (N = 60)—moving towards an integrated understanding of the impacts of DFV on children and other family issues ($t[59] = -3.22$, $p = 0.002$). However, there was no significant difference between pre-COP personal practice scores and organisational scores for Scale B (N = 60)—holistic practice supporting child and adult survivors in the context of their family ($t[59] = -1.97$, $p = 0.05$).

At the end of the CoP phase, the difference between organisational and personal practice was perceived to be greater than the pre-CoP rating difference for both scales. Personal practice scores were significantly higher than organisational practice scores for Scale A after the CoPs were run ($t[64] = -3.73$, $p < .01$). Personal practice scores were also significantly higher than organisational practice scores for Scale B post-CoP ($t[63] = -4.64$, $p < .01$).

The perception that personal practice was more advanced in implementing a child-focused, DFV-informed, all-of-family approach to practice than organisational practice applies both before and after the CoP phase. Before the CoPs, the largest mean difference was for Scale A, concerning practice that was about adults only or integrated with children and other issues.

However, perceived differences between organisational and personal understandings of the importance of integrating child and adult issues was greater at the end of the CoP phase than at the outset. The findings indicate that although practitioners perceived that they had themselves improved their understanding of the interconnected needs of child and adult survivors, they believed that their organisations were slower to take this on board.

2.6 Discussion and concluding comments

This final section summarises and synthesises the findings from interviews with clients, interviews with practitioners, CoP content and questionnaire responses to discuss experiences of the implementation of the S&T Model, and the impact of interventions informed by this model on children and families living with intersecting issues of DFV, MH and AOD. The project's research questions are used to structure the discussion.

1. How do *individual family members* experience the interventions they receive when they are clients of an organisation that is implementing the S&T Model when working with children and families living with DFV and where there are parental issues of MH and/or AOD?

The 23 clients who were interviewed as part of the case study component included 13 mothers, five fathers and five young people. They were all clients who had been supported for some months by organisations that were committed to an all-of-family approach to working with children and families.

Interviews with family members illustrated the positive impacts of changing practice with families living with DFV, where there were additional complexities of parental substance use and/or MH. In the main, clients highlighted the meaningful ways in which workers trained in the model had worked with their families and shaped their experience of services. All interviewees spoke of positive experiences with their service, including significant changes in their families and being treated respectfully by workers. In particular, respectful and inclusive engagement with young people appeared to be central to how successful they viewed an intervention to be. Effective practitioners have both the confidence and the skills to engage young people.

These good experiences were not universal. Many clients spoke of the practitioners who worked with them as providing a service that contrasted dramatically with previous service interactions, and with practice by workers who had not been trained in the model. There were also many stories of past interventions where children's experiences and welfare were ignored or their needs in relation to their unique experience were not taken into account. Interviewees had experiences of practitioners focused on family deficits rather than the resilience and strengths of child victims/survivors and their non-offending parent.

Two approaches were raised by family member interviewees as effective. The first was the use of S&T tools, such as the perpetrator mapping tool. Though often a painful exercise, adult victims/survivors who worked through this with a practitioner found it valuable in helping them understand what had happened to them and their children. Secondly, all-of-family approaches were commended, in which practitioners partnered with mothers to keep the children safe at home; engaged honestly and openly with fathers; and engaged with children and young people in age-appropriate ways, listening to them with respect and including them in decision-making processes. Clients also valued service accessibility, in terms of flexibility in practitioner contact arrangements, practical support and the chance to work with the same practitioner over a period of time. Finally, family members stressed the importance of interagency communication and collaboration in ensuring effective practice at the intersections of DFV, MH and AOD services.

2. How have *practitioners* experienced the implementation of the collaborative S&T Model within and across their organisations when providing interventions to children and families living with intersecting issues of DFV, MH and AOD?

Practitioners in this study reported an increase in the degree to which they recognised the centrality of children in perpetrator patterns of power and control and the multitude of ways that children are impacted by DFV, parental substance use and MH issues. This is a significant shift away from historic representations of children as incidental, silent or invisible victims of DFV, or merely as appendages of their mothers. Interviews with workers across a range of services and sectors

illustrate increasing awareness of the impact on children of DFV, AOD use and MH issues. This knowledge is enhancing these workers' ability to undertake a comprehensive assessment of children's needs, which is translating into improved interventions, including safety planning with children and mothers, and direct engagement with children.

Several practitioner interviewees reported that the S&T perpetrator mapping tool was valuable in helping them make significant changes in how they partnered with mothers. It kept the harm done to children in view, in light of what it showed about a perpetrator's pattern of abuse and coercive control and the role of AOD and MH in his behaviour. This tool provided both a therapeutic and educational opportunity for building a solid relationship of trust and transparency with mothers, even when they were struggling with their own substance use and MH issues, and a clear advocacy opportunity that could lead to good outcomes for child and adult victims/survivors—keeping or returning children to the safety of being with the non-offending parent.

In interviews and questionnaire responses, practitioners cited a range of organisational and individual practices to illustrate the child-focused interventions that are now taking place, including engaging with children in age-appropriate ways, advocacy, practical support, and interagency communication and collaboration.

However, despite this enthusiasm and increased confidence, many practitioners also recognised that these changes are in their early stages and that wider implementation of the model is needed. Many agencies across sectors promote themselves as child-focused, but the data provide just as many examples of practice in which children are invisible or not seen as victims/survivors of DFV in their own right. This applies to family-focused services such as CP and particularly to adult-focused services such as AOD and MH.

Hearing and acting upon children's and young people's voices is critical to implementing the model, but their absence from practitioners' CoP presentations was a source of concern. Children were most frequently mentioned in CoP case discussions as a motivational factor for fathers' engagement or for shifting behaviours, and in relation to their removal from the family home. However, these discussions still focused on the work with fathers or mothers. Relatively few case examples were provided by practitioners detailing their direct interactions with children. These related to work with children in early to middle adolescence, and included interviewing children to understand their behaviours, advocating for children in schools, and working with children's wishes around contact and reunification, thereby ensuring child participation in decision-making. For children too young to participate in decision-making, practitioners described working in their best interests.

The findings from the continuum exercise reinforce this picture of change in its infancy. While there was a perceived improvement in both organisational and (even more so) personal practice, for organisations and practitioners involved in the CoP capacity-building process, respondents believed that further change was necessary. Organisational practice, despite improvement, was seen to remain at a "pre-competent" level in relation to DFV-informed, child-focused work. Greater organisational commitment to documentation of DFV concerns (particularly through tools such as the S&T perpetrator mapping tool) would embed better DFV-informed practice, so that it is not dependent on individual skill. Starting from a slightly higher base, personal practice was perceived to have improved to "competent" levels, though skills and confidence in engaging children and young people were still variable. Neither organisational nor personal practice was seen as "proficient".

2.6.1 Limitations of this study

There are a number of limitations of this study that should be noted. The CoP and case study methodology was appropriate for the exploratory approach of the STACY project, which sought to understand client and practitioner experiences of S&T-informed practice with people at the intersections of DFV, AOD and MH. However, the approach has its limitations in collecting detailed and specific information. Interview questions were designed to be open-ended and to act as a conversation guide, and had a broad focus. There were no specific questions about service engagement with children.

The findings of this study are based on a secondary analysis of

data originally collected without a specific child focus. While this has enabled researchers to note the areas where children are taken into consideration, many gaps have also become apparent. As is common with exploratory research, general themes have emerged from the conversations undertaken in this research, which warrant further investigation.

A number of voices were missing from the CoPs and the interviews. In particular, no MH practitioners were interviewed, and few participated in the CoPs. A number of case examples were presented in the CoPs which illustrate the difficulties of working at the intersections of DFV and MH.

It was not possible to include a specific Aboriginal and Torres Strait Islander strand in this study. There is an urgent need to develop interventions that support Aboriginal and/or Torres Strait Islander children, families and communities who face intersecting challenges, not only of parental AOD use and MH in the context of DFV, but also of intergenerational trauma, housing instability and structural disadvantage. There has been some strong leadership on culturally appropriate practice that has been informed by the S&T framework, particularly in Queensland. However, this remains work for future projects led by Aboriginal and/or Torres Strait Islander practitioners and organisations.

In addition, the project did not allow scope for consideration of the specific needs or perspectives of culturally and linguistically diverse communities, due to its exploratory nature. This is another area warranting further investigation.

2.6.2 Concluding comments

Practitioners trained in the S&T Model express enthusiasm for the model and describe significant changes in their practice towards child-focused, DFV-informed interventions. This is borne out by the experiences reported by family members who have used these services, and is reflected in previous publications reporting on earlier studies using the model (Humphreys & Healey, 2017; Healey, Connolly, & Humphreys, 2018; Healey, Humphreys, et al., 2018). The CoP model methodology for capacity-building DFV-informed practice has been reported to be invaluable to those practitioners who participated, and to many of the organisations and practitioners they worked to influence.

It is clear from the evidence, however, that DFV-informed work with children is still in its infancy. Challenges to integrating adult-focused practice with children and their needs, and to recognising child safety and wellbeing as tied to that of the non-offending parent, are experienced across sectors, in CP and family services, DFV services and the AOD and MH sectors.

A particular challenge that has emerged in this study is that faced by practitioners from adult-focused services in working with children. The organisational culture may not support all-of-family work, and practitioners not exposed to a model such as S&T do not understand how AOD and MH issues intersect with DFV both for men who use violence and for child and adult victims/survivors. Even for practitioners who participated in the CoPs, it appeared difficult to discuss case examples without losing sight of the children and re-focusing on the adults in the family. Further research using the CoP methodology has the potential to contribute significantly to effective practice in adult-focused services that promote child safety and wellbeing.

Similarly, the S&T Model is of assistance in teasing out the complexities that occur when working with families in which adolescents are using violence. Further research to develop practice that understands adolescents' own experiences of DFV while helping them become accountable for their behaviours is needed.

Effective child-focused practice at the intersections of DFV, AOD and MH does not become embedded in organisational and practice culture without an authorising environment within organisations involving DFV-informed and child-focused policies and procedures and training of staff at all levels. Some very effective change has occurred as a result of organisations structuring an all-of-family approach into practice. However, there is a long way to go across all sectors to re-orient service systems to the principles of the S&T Model: engaging with men who use DFV as fathers, and focusing on

their parenting; partnering with mothers to support them in managing AOD and MH challenges while keeping children safely in their care; and listening to children's perspectives and including them in decision-making processes. Further research to promote organisational and systems change in these areas and build interagency communication and collaborative practices is a priority.

CHAPTER 3:

Study 2: Exploratory quantitative analyses of the wider impact of Safe & Together in intervention regions

Over the past decade, research has repeatedly shown the negative impacts of DFV on children's wellbeing and development (Macvean et al., 2015). Furthermore, even if children are not directly targeted by perpetrators, DFV can have significant, negative effects on their development and wellbeing (Evans, Davies, & DiLillo, 2008), and the presence of DFV within a household has been associated with several forms of child abuse and neglect (Bedi & Goddard, 2007; Holt et al., 2008).

This study explores the wider changes across the child protection system that followed the implementation of the S&T approach in a particular trial site from October 2016 onwards. As part of this practice change intervention in the region, a specialist worker is placed within a particular Child Safety Service Centre (CSSC) to support and inform the child protection process from a DFV-informed perspective. The process is built on a partnership with mothers and non-offending parents as well as close collaboration with MBCPs. From an implementation design perspective, S&T was implemented as a champion-based model, where a subset of staff would be initially trained in the S&T approach. These champions then facilitated the implementation of DFV-informed child protection practice within the CSSC, which will be referred to as Site C throughout this study.

Overall, S&T was expected to influence the child protection process at different points throughout investigation and assessment (I&A) phases as well as during the ongoing intervention phase (see Appendix C). In particular, the introduction of a DFV-informed practice approach was expected to have effects on the safety assessment, the family risk evaluation and consequently the planned intervention. An expected direct outcome of this intervention was to increase the capacity to identify and record DFV as a family risk factor (see also Appendix E). A potential intermediate outcome would be the reduction in placements of children in OOHC. Figure 8 illustrates the expected points of impact for the S&T intervention in Site C from the notification phase to ongoing intervention.

Figure 8: Expected points of impact of S&T on child protection process in Site C

The aim of this study is to investigate the extent to which S&T was associated with child protection outcomes for children and families in Site C during the first 30 months after its introduction. In particular, this study aims to answer the following research questions as part of the overall STACY for Children project:

3. Have there been higher rates of DFV identified in the trial site following the introduction of S&T compared to comparison areas?
4. How have children's and families' post-substantiation child protection outcomes changed since the implementation of a DFV-informed, S&T approach to child protection?
5. What are the intersecting complexities of DFV, AOD and MH and how do they relate to children's pathways through the child protection system?

In addition to these research questions, this study was also a pilot exploratory study to assess the feasibility of a larger scale investigation into the effects of the implementation of S&T within child protection systems in Australia.

It is important to note that it was not the aim of this study to evaluate the effectiveness of S&T itself, but to conduct an exploratory analysis of the early impacts of the *availability* of S&T on child protection process outcomes at the trial CSSC. This distinction is crucial, especially considering the short follow-up period available for the presented analyses.

Given the complexity of the service system, identifying systems impacts using observational study designs is challenging, as it is difficult to attribute any changes observed in the data to a particular intervention. Following the findings of the *Not Now, Not Ever* report on domestic and family violence in Queensland in 2015 (Queensland. Special Taskforce on Domestic and Family Violence in Queensland, 2015), the family service system was subject to substantial changes and intervention across the whole state.

In addition, there were substantial restructuring efforts across CSSCs in Queensland over the preceding years, including in the Site C area, which complicated the introduction of S&T. Among those changes, the most significant one was possibly the opening of an additional CSSC in the region in October 2017. This means that any effects of S&T beyond October 2017 cannot be disentangled from effects of an additional CSSC.

Together, these dynamics pose significant challenges to the analysis of system impacts, which are exacerbated by the short project timeline and related constraints on data availability. These limitations have to be considered when reading the findings, and consequently this study was designed as an exploratory analysis rather than a causal analysis of the effects of S&T. A detailed description of the project timelines, data limitations and implications for the study is provided in Appendices D and E.

3.1 Methodology

This exploratory study is based on an observational research design using child case-level, de-identified administrative records extracted from the Integrated Client Management System (ICMS), the case management system maintained by QDCSYW. To answer the research questions stated in the previous section, the methodological approach includes a combination of descriptive analytics and comparative case study designs including pre–post and non-equivalent comparison models.

As S&T is expected to impact the child protection process at different points, methods to address research questions will differ. This becomes apparent when considering the trajectories of notifications through the child protection process (see Appendix C). As notifications pass from intake through investigation and assessment to ongoing interventions, the eligibility of a particular notification to reach a given stage will depend on the previous decision point in the process. For example, according to the *Child Safety Practice Manual* (Queensland. Department of Child Safety, Youth and Women, 2017), only children who are assessed as being in need of protection may be subject to an ongoing intervention with parental agreement or child protection order. As such, an analysis of the changes in planned interventions and child protection orders should be restricted to this sub-cohort of notifications. On the other hand, identification of DFV as part of the risk assessment process should be assessed

using all notifications that completed the investigation and assessment step. Therefore, the datasets, and consequently analytical approaches, used to investigate each research question differ due to the outcomes of interest being situated at different points of the child protection process.

3.1.1 Analytical approach to research questions 3 and 4

Research questions 3 and 4 consider interactions between S&T participants and the child protection system and are focused on changes over time. Study Site C is compared over a period of time with a group of CSSCs that did not use an S&T approach to child protection. The analytical approach to investigating these two research questions was similar and involved the following three steps:

1. graphical analysis of CSSC-specific time series and descriptive statistics
2. pre–post analysis of Site C data
3. comparative case study using non-equivalent comparison CSSCs (i.e. CSSCs that do not use an S&T approach to child protection).

3.1.1.1 Graphical analysis of CSSC-specific time series and descriptive statistics

As a first step, data measuring outcomes and characteristics of parents, children and cases before, during, and after participating in the S&T program in the CSSCs are plotted against time in a series of graphs. These time series data record information for a single unit at different points in time. If the introduction of S&T led to widespread system effects in Site C, we would expect to see an irregularity (or break) in the behaviour of the time series during or soon after October 2016 when the S&T program began. If the behaviour change lasts, then the time series should show different behaviour before and after the introduction of S&T. And if the behaviour change is only observed in Site C, this would strengthen an argument that the S&T intervention contributed to the behaviour change. This causal argument is based on an assumption that there were no other interventions being implemented at the same time to attribute the behaviour changes to.

3.1.1.2 Pre-test–post-test design

Pre-test–post-test analysis studies are popular for evaluations using observational data, or data that are collected by an outside observer as opposed to self-reported or survey data.[3] As described above, this approach investigates breaks in the behaviour of data before and after an intervention. As mentioned above, causal implications depend on several assumptions (see Appendix E) and several threats to validity[4] must be considered (see Shadish et al., 2002). In this study, pre-test–post-test analysis models will only be used as descriptive

3 By contrast, an experimental design like a randomised controlled trial would involve two randomised groups of participants with one group receiving the intervention and the other not receiving it.

4 Threats to validity refer to trustworthiness and meaningfulness of what is being measured, and what is included and excluded in the study.

KNOWLEDGE TRANSLATION BOX 1: RESEARCH DESIGNS EXPLAINED

Pre-test–post-test design: a research design that tries to measure the effects of an intervention by examining changes in the patterns of the data by comparing the period before the intervention with the period after the intervention.

Comparative case study using non-equivalent CSSCs: a research design that compares changes over time in the trial site to changes in comparison sites to try to remove non-intervention-related effects that may have led to the observed patterns in the trial sites. The term non-equivalent comes from the fact that the intervention was not randomly assigned to the sites (Shadish, Cook, & Campbell, 2002).

analyses to investigate whether there were changes in the variables of interest that may potentially signal the presence of S&T. No causal interpretation of the relationships in the models will be attempted, as is discussed in latter sections.

3.1.1.3 Comparative case study using non-equivalent CSSCs

While pre-test–post-test analysis designs reveal whether the pattern in an outcome variable (e.g. DFV identification) changed over time, attribution of such changes to S&T hinge crucially on the absence of other interventions or state-wide changes after October 2016 that may have impacted on the outcome.

Analytical designs that can control for such effects up to a certain extent are based on comparative case study approaches. These are extensions of previously described designs and include difference-in-difference estimators (see Angrist & Pischke, 2009), interrupted time series with non-equivalent comparison group (see Shadish et al., 2002), and synthetic control group methods (Abadie, Diamond, & Hainmueller, 2010), among others.

In their simplest form, these methods can provide accurate estimates of the effects of an intervention by controlling for unobserved differences in the sites under the assumption of parallel trends and independence of treatment assignment (see Appendix E). In other words, an effect of the implementation of S&T in Site C could be identified if the assumption holds that the trial site would have followed an identical trajectory across time as the comparison sites and there is no selection bias, meaning that the sites are in fact comparable (Cerulli, 2015).

As the dataset employed for the analysis includes several years before the implementation of S&T, the validity of the parallel trend assumption can be assessed. However, whether any unobserved factors influence the differences between sites cannot be tested. As is discussed in the limitation sections of this study, analyses of the time series data cast doubt on the validity of the parallel trend assumption, while the dependence on reporting data for this study introduced challenges that invalidate the independence assumption (see also Appendix E).

Therefore, this study does not intend to establish an inference about causal relationships between S&T and the outcomes of interest, but merely describes features of the child protection system in Site C relative to other CSSCs.

Rather, the current study used models similar to those mentioned above to investigate whether patterns in the data are unique to Site C, compared to other CSSCs, without making claims about causal relationships. While such differences in patterns could not be causally attributed to S&T, they are informative and may serve as a basis for future causal analysis, if required data for causal interpretations are available.

3.1.2 Analytical approach to research question 5

The final section of this quantitative analysis focused on the complex interactions of DFV, MH and AOD use on the pathways of children and families through the child protection system.

To explore these constructs, three different approaches are taken: 1) a graphical analysis of the patterns observed in the data; 2) simple ANOVA-type logistic models which explored the relationships between DFV, MH and AOD, and outcomes of investigations, as well as OOHC placements; and 3) fully flexible conditional inference trees (Hothorn, Hornik, & Zeileis, 2006) to investigate combinations of identified risk factors and their association with outcomes of interest.

3.2 Data

3.2.1 Data extraction and preparation

Following approval by the University of Melbourne Human Research Ethics Committee, the research team worked closely with the Data Analysis and Reporting Unit at QDCSYW to develop a feasible data extraction plan and identify possible comparison sites for the analyses.

KNOWLEDGE TRANSLATION BOX 2: RESEARCH DESIGNS EXPLAINED

Binary logistic regression: a type of regression model that is commonly used for binary outcomes. Traditional regression models for continuous outcomes (e.g. multiple linear regression) model the expected value (or the mean) of the population. For binary variables, the expected value is simply the probability, which cannot be smaller than 0 or larger than 1. By using logistic regression, it is guaranteed that the predicted value is bound between 0 and 1.

ANOVA-type logistic regression: this describes a logistic regression model where all predictors (i.e. independent variables) are binary (i.e. either take the value 0 or 1, also called dummy variables). In this case the model fits cell proportions and if all interactions between dummy variables are considered in the model, then this model will always fit the data (in other words, the model is saturated). This approach is similar to ANOVA models for continuous outcomes, hence the name (Harrell Jr., 2015).

Conditional inference tree (CIT): a specific type of classification model that is similar to the widely known classification and regression trees (CART; see Hothorn et al., 2006). These models are usually used for predictive models. CIT has several advantages over CART and is based on a well-defined statistical theory. This also enables us to use it for analysis of correlation structures in the data. CIT (like CART) works on the basis of separating the data sample into non-overlapping groups. By doing so repeatedly, it can generate classifications of outcome groups even with many predictors and complex interactions between variables. This makes it an attractive tool for exploratory analyses. The repeated application of this splitting process is referred to as recursive partitioning.

Given the short timelines for this project, it was decided that it was not feasible to request project-specific data extracts; instead, already available datasets used by QDCSYW for period reporting were employed. Furthermore, the number of comparison sites was limited to facilitate the data extraction process. Selection of comparison sites was based on expert advice from QDCSYW regarding overall similarity of the sites, client characteristics and child protection interventions. Overall, five comparison sites were chosen (A, B, D, E, F). Based on the research questions, the data extract included information on all notifications received between 1 April 2013 and 31 March 2019.

Data files were transferred by QDCSYW to the University of Melbourne using the department's secure transfer platform. This process was completed during the first half of October 2019. In total the data extract included 19 individual datasets spanning four components of the child protection process: investigation and assessment (I&A), ongoing interventions, orders, and family risk evaluation (FRE) outcomes. Each dataset, with exception of the FRE files, covered a single reference period. More detailed explanation of each dataset, coverage periods and data management processes are provided in Appendix D. Following data transfer, data were assessed for structural integrity and were subsequently processed to produce datasets that can be used for analysis. This process included the construction of aggregate time series at CSSC level and longitudinal datasets at either child-event level or event level depending on the unit of analysis. Exact data specifications are provided in the individual analysis sections below.

3.2.2 Data limitations

A major implication of the reliance on reporting data for this analysis is that individual investigations were followed only up to the periodical data extraction date, which is 31 May of each year. After this point in time, no further information on investigations that started prior to this date is included in the extract. This generated missing values on data collected during the I&A phase for 10.6 percent of all notifications in the dataset. If these outcomes are missing due to a systematic pattern, then the completely observed I&A cases will not be representative of the total cohort of notifications captured in the data (see Appendix E). However, if outcomes are missing purely due to timing issues, then the fact that these I&A are not completely observed will have little impact on our findings for research questions 4 and 5. To investigate implications of missing values on the presented results, an assessment of the missing value patterns is provided in Appendix E. Similar to the I&A datasets, a data extraction process for the FRE items resulted in missing values for 11.5 percent of all recorded notifications (of which 7.6% actually had a recorded I&A outcome). These missing values are especially relevant for research questions 3 and 5, as the FRE items are directly included in our models to answer these questions. For research question 4, the missing FRE values are only indirectly relevant in so far as they cannot be included as

covariates in some of the models due to themselves being potentially affected by the introduction of S&T.

3.2.3 Cohort characteristics

This section provides an overview of the characteristics of children, aged zero to 18 years, who were subject to notifications in each CSSC between 1 April 2014 and 31 March 2019. The decision to exclude notifications recorded between 1 April 2013 and 31 March 2014 from the analysis was due to two considerations. Firstly, excluding the first 12 months of data provided a consistent history for all included notifications. It enabled the generation of several variables to control for children's interaction with child protection in these CSSCs within 12 months prior to the first included notification. Secondly, the integration of two centres (resulting in Site A) between 2013 and 2014 resulted in an increase in notifications in this centre. As such, excluding the first 12 months of data from the analysis reduces the "noise" resulting from this restructure.

In the final dataset, 14,650 individual children were recorded in the dataset as part of 9265 notifications, resulting in 21,190 rows of data (i.e. child–notification combinations). On average, children were subject to 2.1 notifications during this period, with the number of notifications per child ranging from one to 10. However, the vast majority of children in the dataset only had one recorded notification during the observation period (72%). Most notifications included more than one child (82.8%) with an average of 3.2 children per notification (range: one to 12).

Table 4 presents information on several characteristics of notifications in each CSSC. The information presented in the table refers to notifications and not children, which has to be considered in light of the 28 percent of children with multiple notifications. As can be seen, the numbers of notifications recorded in each CSSC vary substantially. With the exception of one site (Site F), Site C experienced approximately twice the overall demand when compared to the other CSSCs. Children subject to notifications in Site C were slightly older, on average, than in other CSSCs ($p < 0.02$), with the exception being Site F.

Site C also received a larger proportion of notifications that included Aboriginal and/or Torres Strait Islander children than other sites ($p < 0.001$),[5] with the exceptions of Site D and Site F. An interesting observation is that Site C had a smaller share of notifications where children were reported to child protection for the first time. In other words, Site C had a larger proportion of children who had previously been subject to an intake. However, notifications in Site C were also less likely to be related to children who were already in care at the time of intake. In terms of family risk factors, Site C appears to be at par with the overall average across most items. However, notifications in Site C had a lower share of caretakers with identified criminal history and a higher share of families with four or more children in the household. When looking at the substantiated types of abuse, Site C is again very close to the overall average across centres, with the only difference being substantiated sexual abuse, which is much lower than in the other centres, except for Site D.

The information presented in Table 4 is averaged across time and does not account for developments that occurred in each area between 1 April 2014 and 31 March 2019. Appendix F provides information of the time series for several variables shown in Table 4. A major finding when considering the time dimension is that there is substantial variation in notification characteristics within CSSCs during the observation period.

5 Aboriginal status was recorded at multiple points in ICMS and is a combination of self-report and third-party assessment. Please see Appendix D for detailed information on this indicator variable.

Table 4: Summary statistics of notifications by CSSC, 1 April 2014–31 March 2019

	Site A	Site B	Site C	Site D	Site E	Site F	Total
Notifications	2875	2976	5365	2906	2625	4410	21,157
Continuous variables[a]							
Mean age (SD)	6.98 (5.10)	6.75 (4.93)	7.25 (4.95)	6.17 (4.92)	6.65 (5.00)	7.29 (5.07)	6.93 (5.01)
Categorical variables[b]							
Aboriginal and/or Torres Strait Islander status	21.5%	18.2%	27.3%	28.3%	22.7%	28.9%	25.1%
Female	46.9%	48.5%	47.1%	49.7%	49.5%	50.5%	48.6%
First intake	18.2%	20.8%	13.5%	16.0%	19.2%	20.4%	17.6%
Notification substantiated	26.1%	22.3%	25.4%	22.2%	26.8%	29.3%	25.6%
Family risk factors[c]							
Caretaker abused as child	40.9%	39.2%	39.0%	43.6%	34.0%	36.7%	38.8%
Alcohol or drug use	61.1%	45.6%	57.1%	60.2%	57.7%	57.8%	56.7%
Complex needs	18.1%	18.0%	17.5%	18.2%	19.2%	13.4%	17.1%
Caretaker criminal history	43.5%	41.3%	36.3%	47.7%	37.1%	56.0%	43.6%
Family and domestic violence	36.5%	34.0%	36.9%	38.6%	37.0%	40.3%	37.4%
Four or more children in household	18.9%	23.7%	23.5%	21.4%	21.0%	16.4%	20.9%
Homelessness/housing	5.2%	3.2%	3.5%	4.7%	3.4%	2.3%	3.6%
Inappropriate parental attitudes/ behaviour	16.4%	8.0%	16.4%	15.6%	18.2%	20.1%	16.1%
Care inconsistent with child needs	8.4%	3.1%	7.4%	9.7%	7.9%	8.6%	7.6%
Caretaker mental health problems	55.4%	42.9%	50.3%	40.2%	46.4%	51.0%	48.3%
Youngest child in home is under 2 years old	30.3%	33.2%	32.5%	37.3%	35.4%	30.5%	32.9%
High risk indicator	40.2%	36.5%	38.0%	44.9%	40.0%	39.7%	39.6%
Substantiated notification characteristics[d]							
Emotional abuse	48.7%	55.6%	49.0%	35.8%	45.9%	44.6%	46.7%
Neglect	32.8%	23.5%	31.9%	45.1%	32.2%	31.1%	32.4%
Physical abuse	12.1%	15.4%	15.6%	15.2%	15.4%	17.9%	15.6%
Sexual abuse	6.4%	5.6%	3.5%	3.9%	6.5%	6.4%	5.3%

Notes: Characteristics presented for notifications. Children can be subject to multiple notifications across different CSSCs.

[a] Variables are based on all notifications recorded between 1 April 2014 and 31 March 2019.

[b] Binary variables include all recorded notifications in denominator.

[c] Family risk factors are based on structural decision making (SDM) FRE items. Items are recorded at notification level, i.e. where more than one FRE form was completed, information was aggregated across all forms. Denominator includes all notifications where an FRE form was recorded.

[d] Denominator includes all cases where a substantiation was recorded, i.e. denominator excludes cases where outcomes were not recorded. Type of abuse categories are mutually exclusive. Categories add to 100 percent.

3.3 Have there been higher rates of domestic and family violence identified in Site C following the introduction of Safe & Together compared to comparison areas?

Given that the S&T framework aims to introduce a DFV-informed practice change through training of child safety officers, the first research question to be addressed is whether one can observe changes in the rate of DFV identification as part of the FRE process in Site C over time. More precisely, is it possible to identify a change in the rate of DFV identification after the implementation of S&T, and if so, is this change different from the pattern observed in other CSSCs?

As data on the DFV history report requests and safety assessments were not available to the research team, the investigation of DFV identification will employ FRE items. It is important to note that these indicators should be thought of as rough approximations and we will address this issue in detail in the study limitations and during the presentation of results.

3.3.1 Data

Whether the introduction of S&T within Site C was associated with identification of DFV is a question situated at the I&A stage of the child protection process. To investigate whether the rate at which DFV was identified in Site C changed after S&T was introduced, data on the FRE items were used. The risk assessment process in Queensland is a staged, circular process that is based on an ecological framework and a cumulative, holistic perspective on harm (QDCSYW, 2015). Information on risk and protective factors is collected from various sources, including file reviews, notifiers, and interactions with the child, family and wider networks (e.g. schools, doctors), as well as direct observations and assessments of interactions between the child and their environment (QDCSYW, 2015).

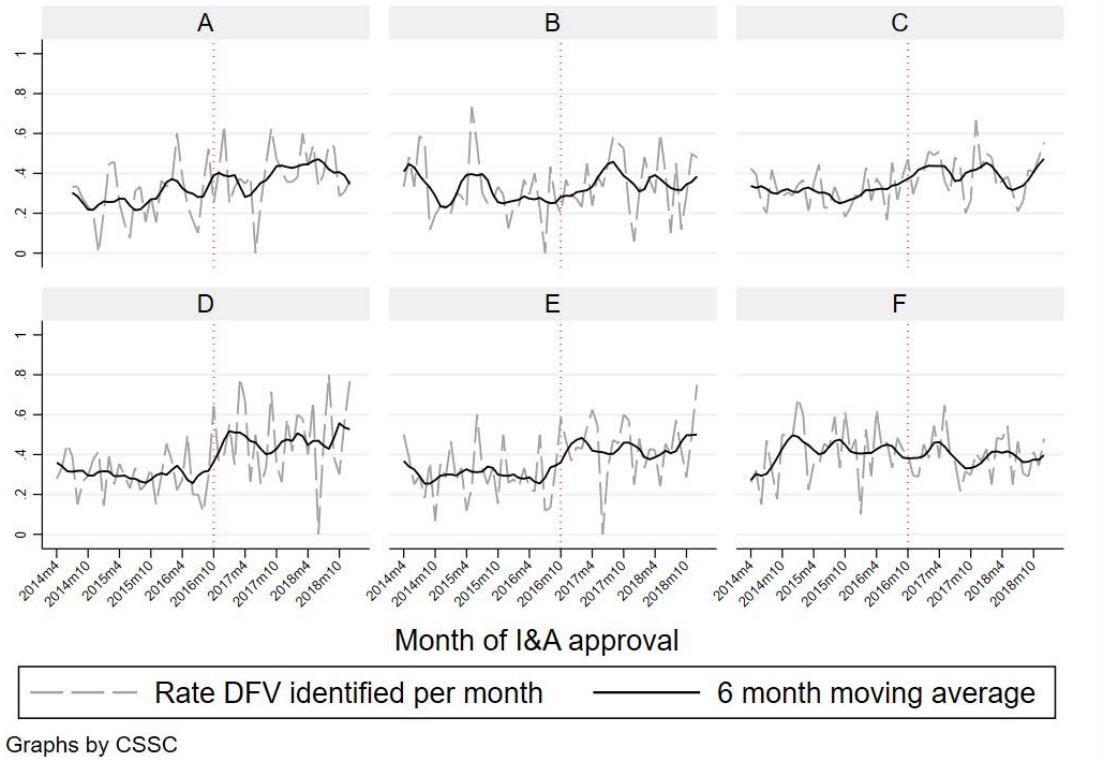
These data were collected using structural decision making (SDM) tools (QDCSYW, 2013) and are recorded in the ICMS at the end of the I&A process (QDCSYW, 2017). As FRE items are recorded at the end of the I&A stage, the subset of notifications used for this analysis included all cases where an I&A outcome was recorded. This resulted in 9.8 percent of the 10,795 notifications at household level being excluded from the analysis.

As mentioned above, due to this analysis using data intended for periodical reporting, not all FRE forms are available for the analysis, even if I&A processes were completed. Given the limitations in the datasets, only notifications with available FRE forms were included, as multiple imputations to address missing values was not feasible. These constraints should be considered when interpreting the findings presented in this section (see Appendix E). Excluding completed assessments without recorded FREs reduced the analysis dataset to 8674 household-level observations. Furthermore, the dataset was restricted to the period from April 2014–December 2018 due to large numbers of missing values outside these date ranges. This resulted in a dataset of 6962 notification-level observations, of which 1892 were located in Site C. This dataset was used for graphical analyses to compare trends in DFV identification among FRE forms across sites over time.

However, for the analysis based on statistical models, only a subsample of these cases were used to ensure independence of the included notifications across time and across sites. As individual assessments and notifications could include multiple children, we accounted for these dependencies among children by selecting only the first case among children who were assessed together as part of any notification at any point in time between April 2014 and December 2018. This minimises the chances that previous assessments would influence later assessments within sites across the compared periods.[6] The final sample of unique notification-level observations for the statistical analyses included 4955 observations, of which 1290 were in Site C.

6 Unfortunately, as data on children's child protection involvement prior to the extract periods are not available, it is not possible to control for dependencies related to assessments conducted prior to April 2014.

Figure 9: DFV identification by CSSC over time with 6-month smoothed series, 1 April 2014–31 December 2018



Note: Vertical dotted line indicates introduction of S&T (October 2016). Grey dashed series represents monthly rate of DFV identification expressed as notifications with DFV indicated as proportion of all notifications with a recorded FRE form. Solid line represents a smoothed time series using a 6-month centred moving average smoothed trend (Bowerman et al., 2005).

3.3.1.1 Dependent variable

The data available to the research team included a set of binary variables indicating whether or not DFV was identified for a particular household during the I&A process (see Appendix D). As is mentioned in the appendix, FRE items were recorded at household level only and were linked to the I&A data using the intake event ID. A consequence of this data structure is that it was not possible to reconstruct child-level family risk profiles, as all children included in a particular notification had the same intake (and assessment) event ID. To address this problem, an aggregate household risk dataset was generated that reflected the identified risk factors associated to a particular notification across all FRE forms. In other words, if at least one of the FRE forms recorded during an I&A process indicated the presence of DFV, the household risk indicator would take the value of 1.

3.3.2 Results

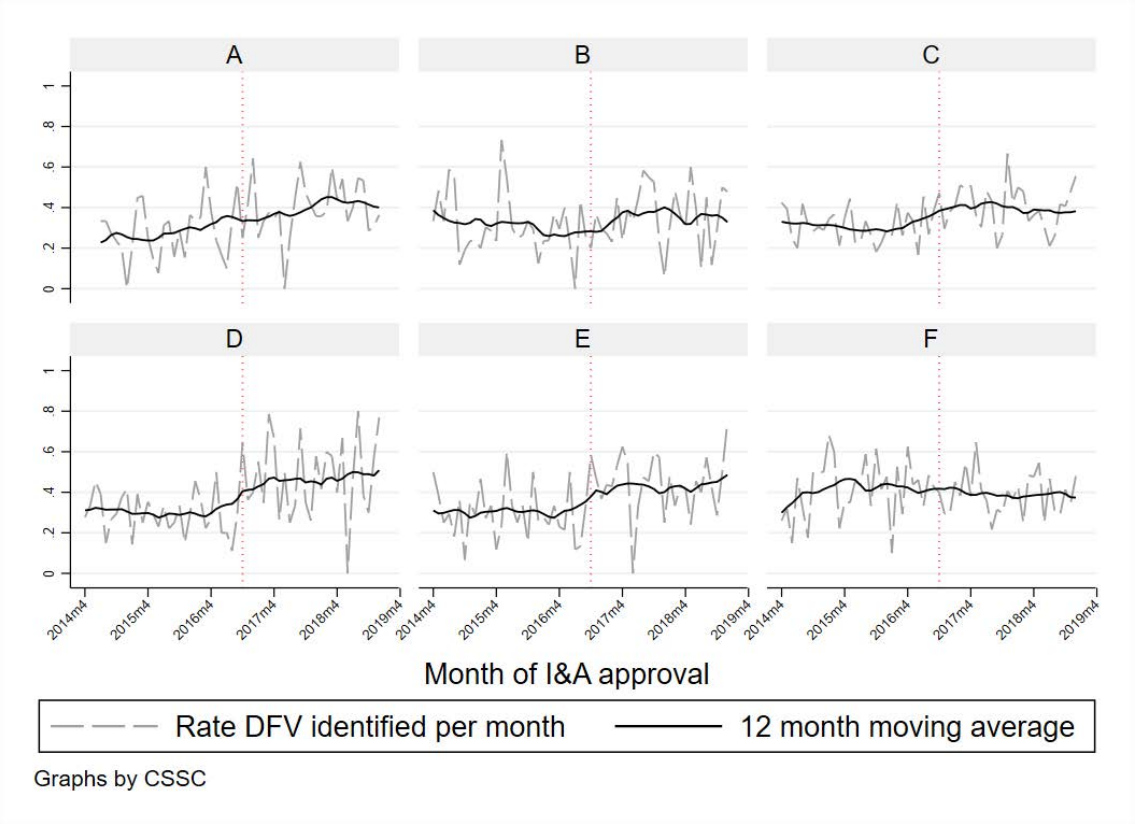
As mentioned above, S&T was introduced in Site C in October 2016. Therefore, if the intervention had the expected effect on the identification of DFV during the safety assessment and FRE stages, one would observe a change in the rate at which DFV is identified after the implementation of S&T. However, it should be cautioned that a change in the rate of DFV identification may also have been caused by other factors such as state-wide intervention efforts or policy changes. Without ruling out alternative causes, it is not possible to fully attribute observed changes to S&T.

Figure 9 illustrates the rates of DFV identification at each CSSC during each month between 1 April 2014 and 31 December 2018. Identification refers hereby to the indication of DFV within the FRE. It is important to assess numbers of DFV identification relative to the total recorded FRE forms to account for changes in the number of assessments over time and differences between CSSCs.

As one can see from the grey dashed lines in Figure 9, there was substantial variation in monthly identification rates of DFV across CSSCs. However, none of the CSSCs exhibited a strong trend in either direction over time, with the exception of Site A where the rate of DFV identification increased steadily over time.

To reduce the variation in the data, a six-month centred moving average smoothing filter (Bowerman, O'Connell, & Koehler, 2005) was applied to the raw data in Figure 9, with the results represented by the solid black lines. The six-month filter was chosen to align with the introduction of S&T in October 2016, indicated by the vertical dotted line.

Figure 10: DFV identification by CSSC over time with 12-month smoothed series, 1 April 2014–31 December 2018



Note: Vertical dotted line indicates introduction of S&T (October 2016). Grey dashed series represents monthly rate of DFV identification expressed as notifications with DFV indicated as proportion of all notifications with a recorded FRE form. Solid line represents a smoothed time series using a 12-month centred moving average smoothed trend (Bowerman et al., 2005).

The smoothed series shows a slight upward trend in Site C that began around October 2015 with additional increased variance from the beginning of the year 2017 onwards. However, these dynamics are not unusual as similar patterns can be seen in other CSSCs (e.g. Site D and Site E). A long-run trend model represented by a 12-month centred moving average series (see Figure 10) eliminates possible fluctuations due to seasonality and other residual noise and corroborates the previous results. Furthermore, these data indicate that for included notifications in Site C, the average rate of DFV identified in FRE forms increased from approximately 32 percent over the period April 2014–September 2016 to 41 percent for the period October 2016–December 2018. Again, similar patterns are observed in other CSSCs and therefore it is not clear to what extent these effects can be attributed to S&T.

To investigate whether there was a change in the behaviour of DFV identification at the systems level in Site C, data before and after the introduction of S&T at Site C were compared using statistical models. Given the restraints imposed by the data as discussed in the limitations section, a simple pre-test–post-test model was adopted, averaging over time points between April 2014 and September 2016 (pre-test) as well as October 2016–December 2018 (post-test). Given that the outcome variable is binary, logistic regression models were used.

The results from logistic regression models are presented in Table 5. Model 1 (column 2) shows the results for a pre-test–post-test design using pooled cross-sections for Site C (see Wooldridge, 2013). To control for possible differences in some of the key characteristics, Model 1 includes a number of covariates. In particular, these predictors include an indicator for at least one child included in the substantiation being from an Aboriginal and/or Torres Strait Islander background, a variable indicating whether the youngest child included in the notification was under the age of 2 at the time of the investigation, and an indicator taking the value of 1 if four or more children were subject to the notification. These variables were derived from the administrative records rather than the SDM risk indicators. The reason for this is that if S&T had an impact on the completion of the FRE items, then FRE items were themselves affected by S&T and must not be included as covariates (Wooldridge, 2005).

KNOWLEDGE TRANSLATION BOX 3: STATISTICAL CONCEPTS EXPLAINED

Log-odds: log-odds is an alternative way of expressing probabilities which facilitates the statistical analysis of binary outcomes because it allows the analyst to express the model as linear regression. It is obtained by first calculating the ratio of the probabilities of the two outcomes (0 or 1), and then calculating the logarithm of the ratio. However, this transformation has consequences for the interpretation of the results as the coefficients in log-odds metric do not reflect the full change in probabilities, which reflect the nonlinear model underlying logistic regressions.

Moving average smoothing filter: smoothing filters are often applied to time series data to reduce the noise so that one is able to see if the data exhibit any trends. There are different filters, depending on the objective of the smoothing. Moving averages (MAs) reduce the variation in the raw data by calculating the average over a certain time span (e.g. 12 months for monthly data). The word "moving" indicates that at each point in time, the average is taken over a certain number of previous periods (lags) and future periods (forward values). This generates a moving window of averages along the time series. Centred MAs are a specific type of this approach that have advantages if the number of months to smooth over is even (Bowerman et al., 2005).

Baseline mean model: in models that compare data from before and after an intervention, the period prior to the intervention is often called baseline. A baseline mean model assumes the absence of a trend during the baseline period and represents the outcome of the pre-intervention period as a constant average. This model is also applied here to address potential problems where outcomes are correlated over time (autocorrelation). The simplicity of this model potentially comes at the cost of model fit to the data, however.

Pooled cross-sections: an approach to modelling repeated measurement data. These models use data collected at different time points together in one sample. In the case of this analysis, different years of data are combined to form a pre-intervention and a post-intervention dataset. These data are then used in a pooled (combined) analysis to see whether there were differences between the groups.

Model comparison: as different models may be used to describe the same data set, it is important to assess whether one model is preferable to another. There are many measures for model comparison. The likelihood ratio (LR) test uses the log likelihood statistics of two nested models to test whether adding (a subset of) covariates significantly improves the model fit to the data. The log-likelihood is the logarithm of the likelihood function, which describes the relationship between a parameter and the data at hand. LR tests should only be used for nested models—in other words, when one model is an extension of the other (e.g. through an additional predictor being included). Akaike's information criterion (AIC) and the Bayesian information criterion (BIC) are alternative measures for assessing model fit. In contrast to the LR test, they apply a penalty for the complexity of models and can also be used for non-nested models.

Difference-in-difference: an approach to evaluating differences between two groups that allows the controlling of group-specific effects as well as time-specific effects that may otherwise bias the estimated parameter. By taking the difference between post-intervention and pre-intervention data for a particular site, site-specific effects can be eliminated under certain circumstances, thus reducing the noise in the estimate. Comparing these differences across groups then enables a more robust assessment of differences between the groups.

Sample selection bias: in statistical analyses (and other scientific analytical methods) generalisation from the data at hand to the larger population is based on the fact that the sample is reflective of the population. This is often done by random sampling. However, if the sample is not drawn at random, the observed patterns in the data may be specific to the sample and may not be generalised to the population. For example, if an unobserved characteristic causes a particular subpopulation to be more likely to participate in a study, then the estimations based on this sample may not be accurate reflections of the population we are trying to describe.

Table 5: Pre-post and comparative case study regression models investigating changes in identification of DFV, Site C and comparison CSSCs

Explanatory variable	Model 1	Model 2	Model 3
S&T	0.22	0.19	-0.15
	(0.13)	(0.15)	(0.22)
October 2017		0.26	
		(0.17)	
Constant	-1.17***	-1.17***	-1.08***
	(0.10)	(0.10)	(0.09)
Additional controls	Yes	Yes	Yes
Number of observations	1290	1290	2001
Log likelihood	-784.34	-784.28	-1251.99

Note: Results from logistic regression models. Data extracted from ICMS database. Included are first completed notifications (among notifications in which groups of children were assessed together within the observation period) with at least one completed FRE form and recorded I&A outcome in the period April 2014–December 2018. Unit of analysis is notification-level. Dependent variable is a binary variable taking the value of 1 if DFV was indicated in at least one FRE form for the notification. Reported are unstandardised coefficients (log-odds metric). Standard errors are in parentheses. Models 1 and 2 include notifications for Site C only. Model 1 is specified as pre-test-post-test design with covariates. Model 2 is specified as a three-period design with covariates as in Model 1. In this model, the post-intervention period is split into pre- and post-October 2017, when the additional CSSC in the region was opened. Model 3 is specified as a comparison in differences between Site C and the average across comparison CSSCs. For better comparability across CSSCs, the time period for Model 3 is restricted to the period spanning 31 October 2015 to 1 October 2017. Reported coefficient for S&T for Model 3 is the unstandardised interaction effect in log-odds metric. Covariates included in all models are indicator variables taking the value of 1 if 1) at least one child included in the notification is of Aboriginal and/or Torres Strait Islander background; 2) the youngest child recorded in the notification was younger than 2 years at the time of investigation approval; 3) there were four or more children subject to the investigation. * indicates $p < 0.05$, ** indicates $p < 0.01$, and *** indicates $p < 0.001$.

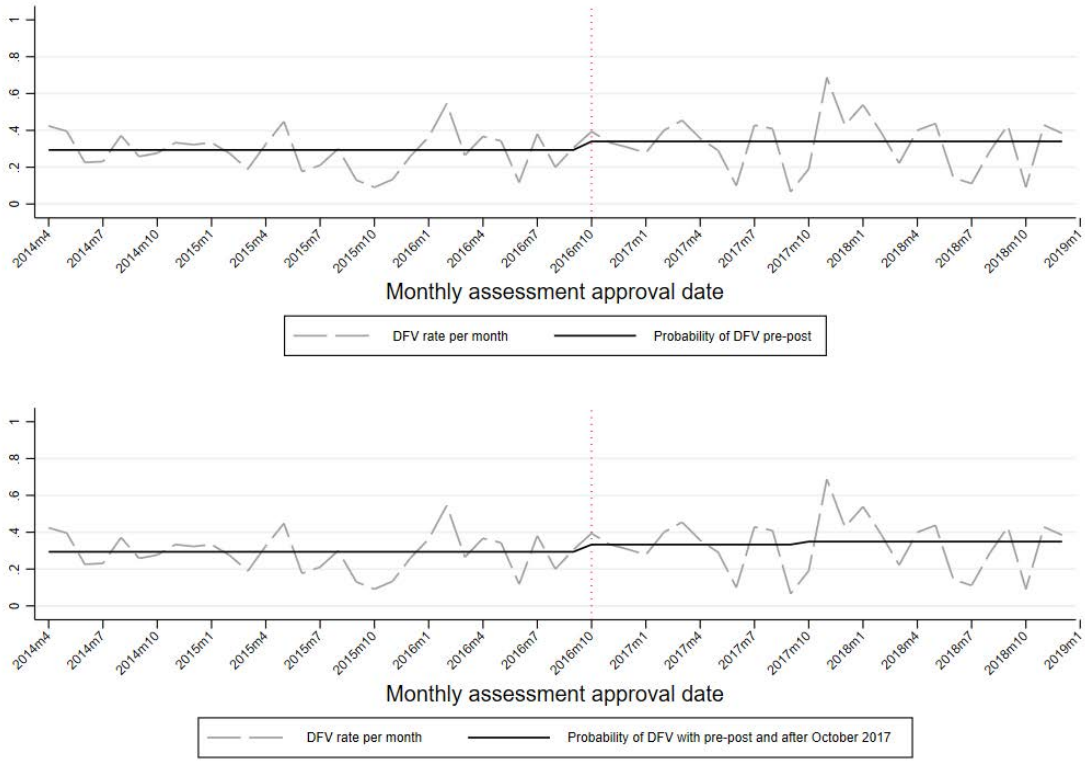
The main results from Model 1 are shown in column 2 of Table 5, which shows the estimated coefficient for the post-intervention period, as defined on the log-odds scale. The association between the post-intervention indicator (S&T) and the log-odds of identification of DFV was not statistically significant. Besides the log-odds metric, it is often desirable to interpret the estimates as probabilities since this takes full account of the nonlinear form underlying logistic regression models. If we change the metric of the result to probabilities, rather than log-odds, then the results show that the introduction of S&T was associated with an increase of DFV identification of approximately 4.6 percentage points, all else being equal. However, this change in probabilities was also not statistically significant.

Model 1 averaged the probability of DFV identification across pre-S&T and post-S&T periods in Site C respectively. Using an averaged probability may not be a reasonable assumption if the effects of S&T changed over time. For example, early implementation effects or staggered roll-out of programs may increase the effect of programs over time. Moreover, as mentioned above, another CSSC was opened in the region of Site C in October 2017, which is expected to have impacted observed data patterns at Site C. Averaging the effects of the introduction of S&T over the whole follow-up period may therefore not be a good measure of change in outcome.

Column 3 of Table 5 shows the results from Model 2, which is similarly specified as in Model 1, except that the post-intervention period is now viewed as two stages, the first spanning October 2016 until September 2017, and the second covering the period from October 2017 until December 2018. During the latter period, the additional CSSC was opened. Again, the findings do not reveal any statistically significant association between either of the two post-intervention indicators and the expected log-odds of DFV identification.

Figure 11 illustrates the findings from columns 2 and 3, where the top panel represents the average probabilities estimated from Model 1 (black solid line) plotted against the rate of DFV identification (grey dashed line). The bottom panel shows the average probabilities estimated by Model 2 (black solid line) for the baseline period (April 2014 to October 2016) as well as for the immediate follow-up period after the introduction of S&T in Site C (October 2016 to October 2017) and the period from October 2017 onwards. The estimated probabilities are again plotted against the rate of DFV identification (grey dashed line). From the graph, it becomes apparent that the change in probabilities between pre- and post-intervention periods was small (and statistically insignificant). Furthermore, the findings presented in the bottom panel show little difference between the first 11 month after the introduction of S&T in Site C and the period from October 2017 onwards. However, there appeared to be a short spike in the raw data series

Figure 11: Estimated probabilities from pre-test–post-test model (Model 1) and model with split post-implementation period (Model 2) against observed rates of DFV identification in Site C, April 2014–December 2018



Note: Top panel—estimated probability from pre-test–post-test Model 1 (black solid line) plotted against the observed monthly rate of DFV identification in Site C (grey dashed line), April 2014–December 2018. Bottom panel—estimated probabilities from Model 2, splitting the post-intervention period into two stages, October 2016–September 2017 and October 2017 until December 2018. All models included covariates to control for Aboriginal and/or Torres Strait Islander status, children in notifications who are under the age of 2 years, and whether there were four or more children subject to the notification.

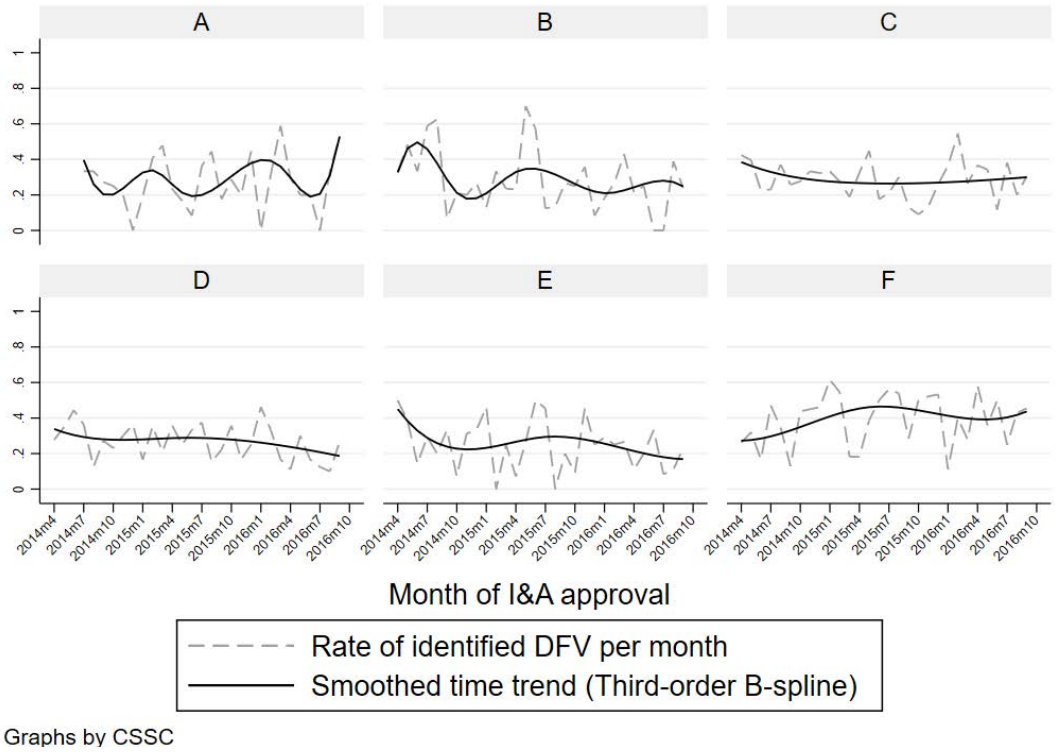
following October 2017, when the second CSSC was opened in the region of Site C.

So far, the models that were discussed only compared data for Site C before and after the introduction of S&T in October 2016. As discussed in previous sections, these models may be subject to several risks (Shadish et al., 2002). For example, these models implicitly assume that there were no other changes affecting the child protection system in Site C during the post-intervention period (October 2016–December 2018). Unfortunately, this assumption is not justified as there was in fact a new CSSC opened in the region in October 2017. This change was accompanied by a reduction in the caseloads of teams in Site C and may at least partially explain the patterns observed in the data and illustrated in the raw data series of the bottom panel of Figure 11. Another cause of concern with single group pre-test–post-test models is that only data from a single intervention group are investigated. This means that state-wide developments could also impact the patterns in the data for Site C that would be wrongfully reflected in the association of the S&T variable with the outcome. To investigate this matter further, the data for Site C were analysed relative to five comparison CSSCs (A, B, D, E and F). This approach is based on comparing differences over time within Site C to differences in time across comparison CSSCs.

The main result of this model is presented in column 4 (Model 3) of Table 5 and in it, as in Models 1 and 2, additional covariates were adjusted to control for differences in notification characteristics over time. To increase comparability of the developments in Site C with other CSSCs, Model 3 only compares assessments that were completed between November 2015 and September 2017. This approach is also expected to address potential impacts of the additional CSSC that opened in October 2017 on the findings.

It is important to note that the coefficient shown for Model 3 in Table 5 is the coefficient of the interaction term between the indicator for Site C and the post-intervention period indicator. The findings from this analysis do not reveal statistically significant effects of S&T (measured in the log-odds metric) on the identification of DFV. The reported interaction term in column 4 of Table 5 has a more complex interpretation

Figure 12: Pre-intervention trends in DFV identification in Site C and comparison CSSCs



Note: Data include identified DFV rates per month in each CSSC between April 2014 and September 2016 for events included in the statistical analyses. To facilitate comparison, data were smoothed using a third-order B-spline series estimator of the DFV indicator on time in months. No additional control variables were included in this model.

in the probability metric. It represents the difference in the change in average probabilities of DFV identification from pre- to post-intervention period between Site C and the comparison sites. In other words, this can be described as the difference in the change in probabilities between the pre- and post-intervention period as we switch from the comparison sites to Site C.[7] When interpreted as change in differences of probabilities, there was a small but negative relationship between the change in probabilities after the introduction of S&T in Site C and the change in probabilities between the pre- and post-intervention period across comparison sites which amounted to (-3.5) percentage points. However, this difference was not statistically significant at the 95 percent confidence level.

Results of this type of analysis can differ substantially depending on the comparison group. If CSSCs in the comparison sample are very different from Site C already during the pre-intervention period, then observed patterns in the data are not attributable to differences in treatment status. A pragmatic way of assessing the suitability of comparison sites for this analysis is to assess difference in the outcome variable during the pre-intervention period. This is illustrated in Figure 12, where the solid line reflects a smoothed time series to reduce the variation between monthly time points and facilitate assessment of trends in the data. If CSSCs in the sample are valid comparisons, then the shape of the smoothed trend line should be very similar to that for Site C. The data illustrated in Figure 12 reveal substantial differences in the data patterns between the comparison CSSCs and Site C during the period April 2014–September 2016. This implies that the results presented in column 4 (Model 3) have to be interpreted in the light of this risk to validity.

Two points of caution should be noted when looking at these results. Firstly, they should only be interpreted for the notifications included in the analysis due to possible influences of missing data. Secondly, the analysis presented in column 4 did not account for possible changes that happened in comparison CSSCs over the observed period. The publication of the *Not Now, Not Ever* report (Queensland. Special Taskforce on Domestic and Family Violence in Queensland, 2015) initiated a state-wide approach to DFV that is likely to have impacted other CSSCs at approximately the same time. This would mean that the CSSCs in the sample would also have received some alternative intervention and therefore would not represent good comparisons, as it cannot be assumed that Site C would have had a trend in outcomes similar to these sites in the absence of S&T.

7 More accurately, this is the change in the marginal effect of moving from the pre- to post-intervention period when the site indicator is switched from comparison sites to Site C. It is important to understand that this effect is not equivalent to the interaction effect on the log-odds scale as it accounts also for the nonlinearity of the logistic model. In these models, the change in probabilities depends on all covariates included in the model.

SUMMARY OF FINDINGS

Based on graphical analyses, the results presented in this section point to some possible early effects of S&T for notifications in the trial site that were included in the analysis. Unfortunately, statistical models were not able to support these findings, showing no statistically significant associations between the introduction of S&T in Site C and the identification of DFV. Considering the limitations of the available data and the complexities in the state-wide system during this period, it is impossible to infer from the data whether and to what extent the introduction of S&T has had an impact on the child protection system in Site C as a whole. To answer this question, more information would be necessary, as is discussed in a later section.

3.4 How have children's and families' post-substantiation child protection outcomes changed since the implementation of a DFV-informed Safe & Together approach to child protection?

Research question 4 investigates how the availability of S&T in Site C was associated with children's interaction with the statutory child protection system. More particularly, this question aimed to assess whether the implementation of S&T in Site C was associated with an increase in the rate of interventions with parental agreement (IPA), child protection orders (CPOs) and OOHC placements.

As explained in section 1.5, the S&T Model is based on a collaborative approach between child protection and the non-offending parent. Given the strong focus on collaboration, it is expected that parents are more likely to be willing and able to work with the department to ensure their children's needs are met. Consequently, if this assumption is true, then a shift in planned interventions and implemented ongoing interventions towards IPAs would be observed which would prevent children from entering OOHC.

3.4.1 Data

From a procedural perspective, research question 4 is concerned with child protection outcomes following the I&A phase, including the type of ongoing intervention and OOHC placements.

An important aspect to note is that, in general, only children who are assessed as being in need of protection may become subject to an ongoing intervention involving IPAs or CPOs (QDCSYW, 2017). To accurately reflect changes in the probabilities or rates of outcomes occurring, only children at risk of being subject to an IPA or placement in OOHC were included in this analysis (see Appendix C). More precisely, only children with a recorded I&A outcome of "substantiated, child in need of protection" were included in the analysis data (n = 3520). Restricting the analysis to the "at-risk" population has the additional advantage that a clear I&A process is defined to inform the analysis (see QDCSYW, 2017).

In line with the analysis in the previous section, the dataset was restricted to the period April 2014 to December 2018 due to the numbers of missing values outside these date ranges. For the analysis of OOHC placements, the date range was further decreased to include only cases with observed I&A outcome prior to 30 November 2018 to ensure sufficient follow-up time after I&A finalisation, as is explained below.

3.4.1.1 A note on data availability related to outcomes

As is explained in Appendix D, it was unfortunately not possible to directly link IPAs to notifications as IPA records were only available at yearly aggregates as an indicator for whether a child was subject to an IPA during a particular fiscal year. Additionally, IPAs did not have a prescribed duration, which made it difficult to identify individual IPA episodes in cases where IPAs were recorded across multiple consecutive yearly records. This shortcoming was exacerbated by the missing outcome patterns for notifications (see Appendices D and E). Overall, any resulting match of IPA records directly to notifications would be unreliable. Consequently, planned ongoing interventions with parental agreement (an investigation outcome)—with or without directive orders—were used as proxy outcomes.

The available OOHC placement data did not include IPA case information. Therefore, data that were used to generate

an outcome variable for OOHC or IPA placements related to children on an IPA or CPO at any time during the period in combination with information on court orders. However, these data could only be approximately linked to notification data by using the order issue dates as described in the subsection below (see also Appendix D).

It is also important to mention that it was originally intended to include re-notifications as an outcome variable in this analysis. However, following the data quality assurance process described in Appendix D and preliminary analyses, it became apparent that a reliable measure of changes in re-notifications could not be generated from the data. This is due to limitations of the available data themselves, the opening of an additional CSSC in the Site C region during the post-S&T period, and the period of time for which post-intervention data are available in general. Furthermore, interpretation of the meaning of re-notification in the present context is ambiguous, as previous notifications are direct predictors of child protection responses. In the case of the available data, approximately 74 percent of all first cases that are observed are in fact re-notifications. As such it is not clear how changes in re-notifications should be interpreted in relation to the introduction of S&T, especially considering the short follow-up period and the fact that cases transitioned from non-S&T to S&T periods. Considering the uncertainties related to re-notifications, it was decided not to include this outcome in the analysis. Appendix G provides additional information on the outcomes measures used in this analysis.

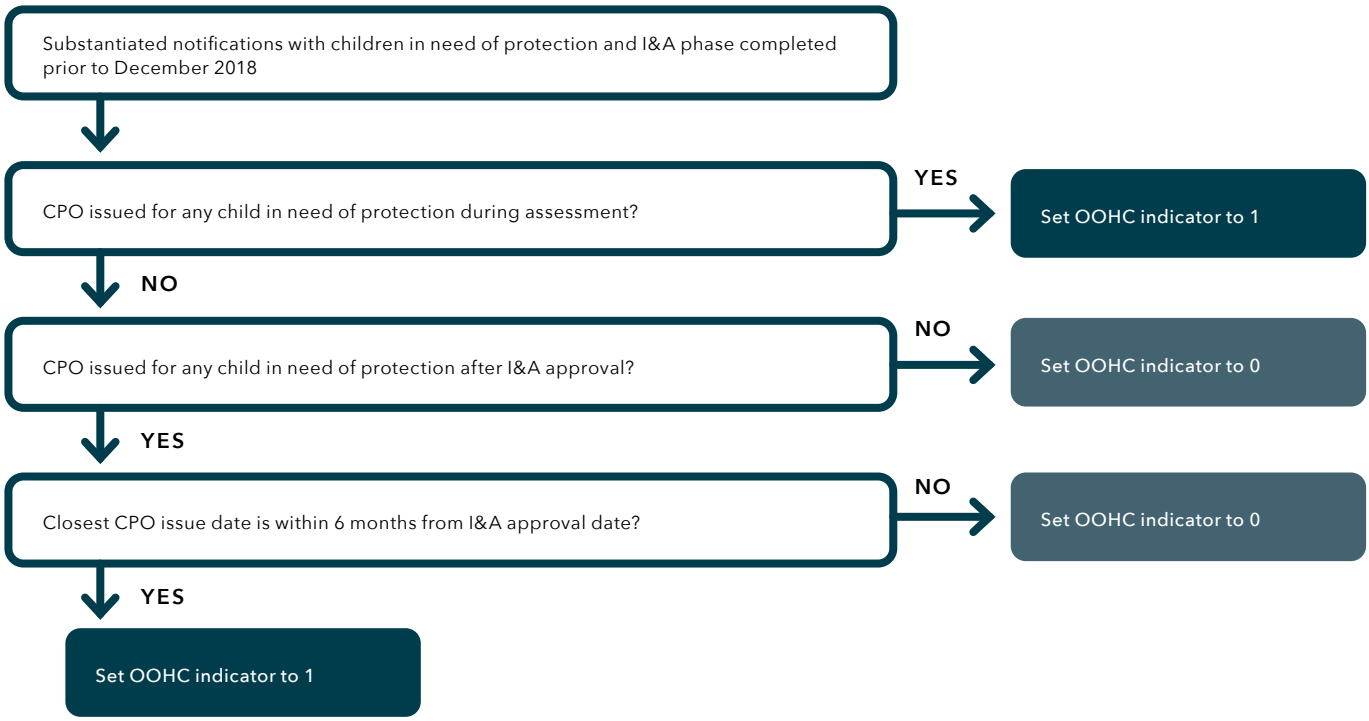
3.4.1.2 Units of analysis and sample size

A particular feature of the I&A process in Queensland is that risk is generally considered a cumulative construct. As such, the decision of whether a child is at risk of harm and in need of protection is generally not an assessment about whether a single alleged incident occurred, but is a holistic response to children being at unacceptable risk of harm in the present or at a future point in time (QDCSYW, 2017). This had substantial implications for the analysis, as observed outcomes for a particular notification would partially be a result of previous I&A processes. Moreover, the dataset available for analysis represented only a snapshot of child protection engagements of children between 1 April 2013 and 31 March 2019. Of the first recorded notifications for children in the data, only approximately 26 percent represented children's first intake. In other words, almost 74 percent of all children in the available data have had previous engagements with child protection in Queensland, for which no information was available for the analysis. As the risk assessment process in Queensland is based on a cumulative and holistic perspective, individual notifications in the data cannot be treated as independent. Furthermore, notifications available in the data cannot be easily interpreted relative to each other, as children's child protection history was not fully available. Consequently, the interpretation of notifications had to be standardised for the analysis.

The challenge of holistic, cumulative decision processes in child protection systems is further exacerbated by the fact that most notifications included several subject children (82.6%). In fact, the majority of notifications included more than two children in a household (60.3%). Hence, individual rows (i.e. observations) in the dataset for different children were not independent of each other. Moreover, as was mentioned during the analysis of DFV, family risk evaluations are conducted at the household level. This means that treating children in households as independent observations is likely to cause substantial bias in statistical inference (see Bryan & Jenkins, 2016; Cameron & Miller, 2015). This is also evident in the outcomes for children in need of protection within a single notification. Of all substantiated notifications with children in need of protection, planned interventions for children subject to the same notification were identical more than 97 percent of the time. Where planned interventions differed, this was mainly due to the presence of children under the age of 2 years or unborn children (74.5%). In these cases, planned interventions were generally support cases. Similarly, the date of the first order placing children in care did not vary across children within the same event in 96 percent of notifications.

Given the strong redundancy in information between children who were subject to the same notification, analyses were conducted at the notification level to avoid issues due to the substantial intra-notification correlation between children. To address the dynamic dependence between multiple notifications including a particular child, only the last substantiated notifications for children were considered.

Figure 13: Algorithm to generate OOHC outcome variable



However, in 4 percent of those notifications, at least one child had one or more subsequent cases. Of these notifications, 12 percent (n = 7) were excluded from the analysis due to variations among planned interventions for children within the notification. Overall, this resulted in 1083 notifications, which had approved assessments recorded between 1 April 2014 and 31 December 2018, being included in the analysis. It is important to note, however, that while this approach addressed challenges related to correlations between children and notifications, it was not possible to address limitations arising from the missing value patterns in outcomes of I&A processes. As such, the dataset may not be representative of the population of substantiated notifications with children in need of protection and results presented in this section may not be generalisable outside the included notifications (see also Appendix E).

3.4.1.3 Dependent variables

Based on the processes described above, two main outcome variables were generated for this analysis: planned IPAs, and OOHC placement within six months of I&A approval (which marks the completion of the investigation and assessment stage).

Planned IPAs as I&A outcome: as direct measures of IPAs were unavailable for statistical analyses, an outcome variable was derived from the notifications dataset by using information on the planned interventions at the end of the I&A phase. Aggregating this variable to the notifications level results in an indicator variable taking the value of 1 if at least one child included in the substantiated notification and in need of protection was placed on an IPA. As reported above, outcomes for children in need of protection within substantiated notifications did not vary for 97 percent of included notifications.

OOHC placement within six months of I&A approval: since CPO data could not be directly linked to notification and investigation information, an outcome variable for OOHC placements was derived by using issued dates of CPOs as an approximation. Unobserved outcomes and court proceedings related to notifications that occurred prior to April 2013 presented a challenge to establishing the relationship between CPOs and notifications. Therefore, the algorithm set out in Figure 13 was developed to derive an OOHC placement outcome variable.

KNOWLEDGE TRANSLATION BOX 4: POPULATION VS SAMPLE STATISTICS

Population: a population contains *all* the units (e.g. individuals, organisations, items, cars) that are of interest to a research question or study. For example, this may include all citizens of a country to investigate inter-regional movements or the total population of children who were in out-of-home care during a particular period to assess family reunification. Target populations of a study are described by precisely defined characteristics.

Sample: a selected subset of the target population that can be used to learn about population characteristics, behaviour, etc. Samples are determined based on a sampling frame and can be drawn in different ways. The main categories are random samples and non-random samples. The former describes a class of samples that are drawn by randomisation, which can take different forms (e.g. simple, cluster, stratified). The latter describes samples that were not drawn at random, which is often the case in qualitative studies, experimental studies and also the analysis of administrative datasets. Non-random sampling may impact the generalisability of the results if sample selection induces bias in estimations (see also "Knowledge translation box 3").

Parameter vs statistic: the characteristic or measurement of interest in the population is referred to as a parameter and it is usually unobserved. A statistic is the estimate of the population parameter based on the sample.

Superpopulation: a superpopulation perspective assumes that the sample at hand was drawn from a population that is assumed to have certain properties and is infinitely large so that results from statistical analyses can be interpreted "as if the sample was randomly selected".

3.4.2 Results

The results of this section will be presented in two parts. First, an analysis of changes in planned IPAs as ongoing interventions is described. Subsequently, the findings from an analysis of the relationships between the introduction of S&T and OOHC placements in Site C are presented.

As explained above, these analyses included substantiated cases where at least one of the children in the notification were assessed as being in need of protection. To address the dependence of notifications for children over time, only the last substantiated notification for a child was used. Subsequently, the dataset was aggregated to the notification level, to account for the fact that the risk and outcomes information recorded for children within the same notification did not vary in at least 96 percent of the included notifications. Hence, the findings presented in the following sections do not present population statistics but sample statistics. Results related to statistical inference should be interpreted as if the analysis sample would have been drawn randomly from a hypothetical superpopulation (see Hernán & Robins, 2020).[8]

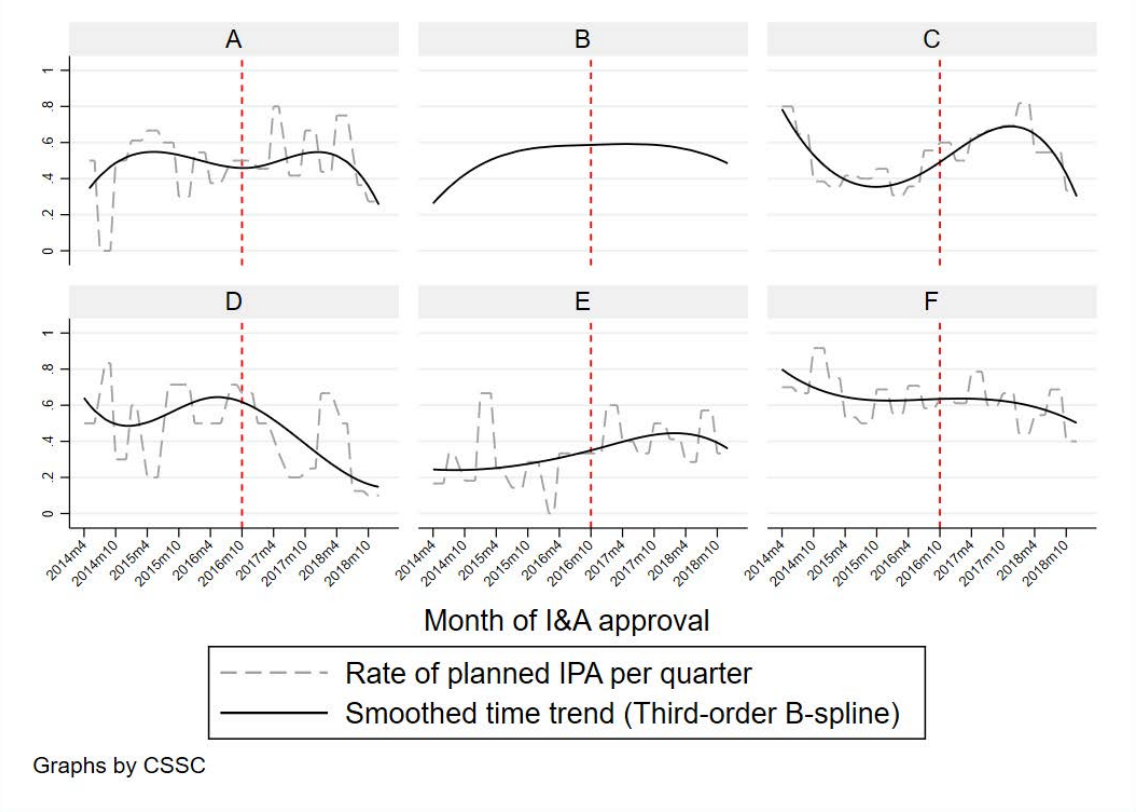
8 See "Knowledge translation box 4" for more details on superpopulations and population versus samples in general. It is also important to note that the superpopulation assumed here would have characteristics comparable to the sample at hand, which needs to be considered in the light of sample selection (see also "Knowledge translation box 3").

3.4.2.1 Interventions with parental agreement

When looking at IPAs as proportions of substantiated notifications with children in need of protection each month, it becomes apparent that there was substantial variation in the data from month to month. When interpreting these data, it is important to keep in mind that only the last substantiated case for children was considered. As was mentioned in earlier sections, it is necessary to assess IPAs as a proportion of substantiated cases to account for differences in the numbers of substantiated cases over time and between CSSCs.

Figure 14 shows the quarterly rates of planned IPAs over time for each CSSC together with a smoothed time series. The quarterly time series for Site B is not shown to ensure confidentiality, as quarterly counts were low in several quarters. It is evident that there existed substantially different dynamics in planned interventions across areas. In the case of Site C, the time series exhibited a nonlinear trend, with decreasing IPA rates between April 2014 and the third quarter of the year 2015. After that point, the share of IPA as planned interventions increased until approximately the third quarter of the year 2017 before decreasing again. However, it has to be noted that the data shown in the graph do not include cases for which no outcome was recorded (10.6%). Rates and trends illustrated in the graph may therefore not be representative of the population of substantiated notifications with children in need of protection for each included CSSC.

Figure 14: Rates of planned IPA by CSSC, 1 April 2014–31 December 2018



Note: Vertical dotted line indicates introduction of S&T (October 2016). Grey dashed series represents quarterly rate of planned IPAs as a proportion of all substantiated notifications where at least one child is in need of protection and the notification was the last recorded notification for children. Included were all notifications where an I&A outcome of "substantiated—child in need of protection" was recorded. Quarterly IPA rate is not shown for Site B to avoid reporting of small numbers. Notifications with missing outcome information were excluded. Solid lines represent smoothed time series using a third-order B-spline series estimator of the planned IPA indicator on time in months. No additional control variables were included in this model.

From the data shown in Figure 14, it appears that, on average, rates of planned IPAs for included notifications were higher after the introduction of S&T than before, especially comparing the quarters immediately prior to and after the intervention. Yet, the positive trend in IPA rates began several months prior to the commencement of S&T in Site C. Without further information, it is unclear what caused this reversal in trend and how much of the observed pattern is due to the implementation of S&T. Overall, the patterns in Figure 14 highlight that a comparison of Site C with other CSSCs must be conducted with care, as there existed substantial differences in the movements of planned IPA rates over the time prior to October 2016.

Table 6 presents the main results from regression analyses based on different specifications. A simple pre–post intervention comparison is presented in Model 1, which is expressed in the log-odds metric of the logistic regression model. The change in levels of the log-odds between the two periods is not statistically significant. In Model 2, additional covariates were included in the estimation to account for possible differences between notification characteristics over time. In particular, the model included the following: 1) an indicator for at least one child included in the substantiation being from Aboriginal and/or Torres Strait Islander background; 2) a variable indicating whether the youngest child included in the notification was under the age of 2 at the time of the investigation; 3) an indicator variable taking the value of 1 if four or more children were subject to the notification; and 4) a variable taking the value of 1 if any child included in the notification had been subject to an earlier notification within the 12 months prior to the intake finalisation of the current notification.

The results for Model 2 are presented in column 3 of Table 6 and are very similar to Model 1. In fact, the inclusion of additional variables does not seem to substantially improve the model and the change in the log-odds between pre- and post-intervention periods is not statistically significant.[9] However,

9 These findings are not surprising, however, as the numbers of observations in Model 1 and Model 2 are relatively small and a specification using average IPA rates for each period does not account for nonlinear trends in the data. As a consequence, the estimates of parameters in Models 1 and 2 are imprecise, as indicated by large standard errors reported in parentheses in Table 6. These results suggest that a model that accounts for nonlinear patterns in the data may be more appropriate. However, the large fluctuations in the time series and the low number of quarterly time points in the pre-intervention period would negatively affect the precision of estimated parameters. In fact, a specification including a quadratic baseline model fitted during sensitivity analyses did not return any

Table 6: Results from pre–post and comparative case study regression models investigating changes in planned IPAs, Site C and comparison CSSCs

Explanatory variable	Model 1	Model 2	Model 3
S&T	0.51	0.54	0.92
	(0.27)	(0.28)	(0.47)
Constant	-0.15	-0.38	0.11
	(0.18)	(0.28)	(0.19)
Additional controls	No	Yes	Yes
Number of observations	233	233	475
Log likelihood	-159.35	-153.54	-319.41

Note: Results from logistic regression models. Data extracted from ICMS database. Included are all notifications with recorded investigation and assessment outcome of "substantiated–child in need of protection" in the period April 2014–December 2018. Unit of analysis is notification level. Dependent variable is a binary variable taking the value of 1 if the planned intervention for at least one child was IPA. Reported are unstandardised coefficients (log-odds metric). Uncorrected standard errors are in parentheses. Models 1 and 2 include data for Site C only. Model 1 is specified as pre-test–post-test design without additional covariates. Model 2 is specified as pre-test–post-test design with additional covariates. Model 3 is specified as a comparison in differences between Site C and the average across comparison CSSCs. For better comparability across CSSCs, the time period for Model 3 is restricted to the period spanning 31 October 2015–1 October 2017. Additional covariates included in Models 2 and 3 are indicator variables taking the value of 1 if the following criteria are met: 1) at least one child included in the notification is of Aboriginal and/or Torres Strait Islander background; 2) the youngest child recorded in the notification was younger than 2 years at the time of investigation approval; 3) there were four or more children subject to the investigation; and 4) any of the children had earlier intakes in the 12 months prior to the intake approval date. * indicates $p < 0.05$, ** indicates $p < 0.01$, and *** indicates $p < 0.001$.

when translated into the change of average probabilities, the period following S&T was associated with a 12.7 percentage point increase ($p = 0.049$). The confidence intervals of these estimates, though, are very wide, highlighting imprecision in the estimated associations.

The final column in Table 6 (Model 3) compares the changes in log-odds in Site C with the average change across other CSSCs. Model 3 included indicator variables to capture differences between Site C and other CSSCs during the pre-intervention period as well as changes in log-odds over time. Given the obvious differences across CSSCs, the analysis period was restricted to 11 months before and after the implementation of S&T in Site C. This decision was also made to exclude any impacts of the opening of the additional CSSC in the Site C region in October 2017. Looking at the data presented in Figure 14, it is much more reasonable to assume comparable trends between Site C and comparison CSSCs during the period from November 2015 to October 2016.

Comparing the changes in Site C to the average developments across other CSSCs yields a statistically insignificant association between the S&T post-intervention indicator and the log-odds of a planned IPA as outcome ($p = 0.052$). When again expressed as the difference in changes in average probabilities, S&T was associated with a 21.9 percentage point increase in the probability ($p = 0.046$) of an IPA being the planned ongoing intervention for at least one child within a notification that was included in the analysis. However, it is important to note that the confidence intervals for these parameters were quite large, signalling substantial imprecision in point estimates. Furthermore, the statistically significant marginal effect related to S&T reflects two components: 1) the substantial differences between comparison CSSCs and Site C prior to the intervention as highlighted in Figure 14; and 2) the difference between comparison CSSCs and Site C after October 2016. As the differences between CSSCs and Site C were already significant prior to the intervention, both statistically as well as practically, this will be reflected in the estimated change of probabilities of Model 3. Overall, the results indicate that the changes in Site C differed from developments across other CSSCs in the sample, but it is unclear how much the introduction of S&T contributed to these differences.

3.4.2.2 Placements in out-of-home care

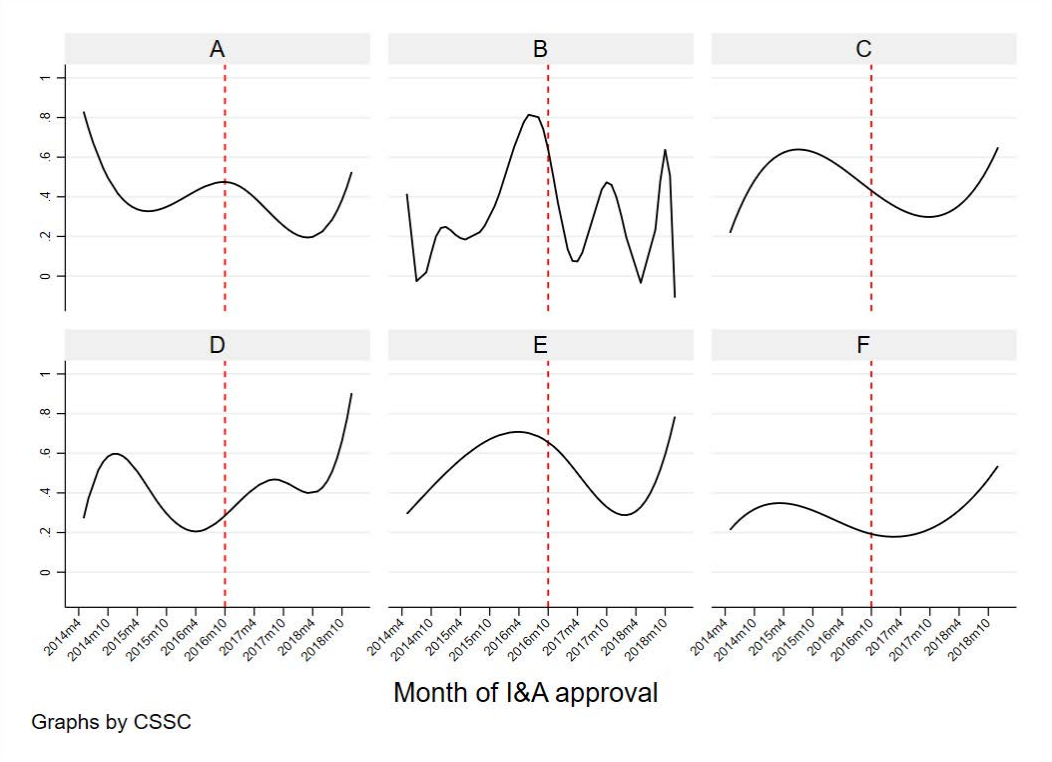
Following the finalisation of the I&A phase, children may have been subject to an ongoing intervention if it was assessed that such a step would be required. For children in need of protection, these interventions can be based on parental agreement or court order (QDCSYW, 2017). Independent of which type of ongoing intervention was planned at the end of the I&A phase, children may still have been placed

statistically significant results for trend parameters. Furthermore, given that notifications without recorded I&A outcome were excluded from the analysis, fitting nonlinear specifications may lead to overfitting. Consequently, it was decided that the change-in-intercept design would be the most robust model for this exploratory analysis.

SUMMARY OF FINDINGS

S&T was associated with a statistically significant increase in the probability (22 percentage points, $p < 0.05$) of an IPA being the planned ongoing intervention for at least one child within a notification that was included in the analysis. However, it should be noted that there were already significant differences between the trial site and comparison sites prior to the intervention, both statistically as well as practically. Overall, the results indicate that the changes in the trial site differed from developments across other comparison sites in the sample, but it is unclear how much the introduction of S&T contributed to these differences.

Figure 15: Rates of OOHC placement by CSSC, 1 April 2014–30 November 2018



Note: Vertical dotted line indicates introduction of S&T (October 2016). Included were all notifications where an I&A outcome of "substantiated—child in need of protection" was recorded and the notification was the last recorded notification for children. Notifications with missing outcome information were excluded. Solid lines represent smoothed time series using a third-order B-spline series estimator of the OOHC placement indicator on time in months. No additional control variables were included in this model.

in care, for example due to events that occurred during the ongoing intervention and case planning phase. One expected indirect outcome of the DFV-informed child protection model introduced by S&T in Site C was a reduction in OOHC placements.

As explained above, OOHC placement was measured as an indicator variable that took the value of 1 if at least one child in a substantiated case was in need of protection and was placed in OOHC between the commencement of the assessment and 180 days (six months) after the finalisation of the I&A phase. To accommodate this follow-up period of six months, only notifications with an I&A phase finalised prior to December 2018 were included in the analysis.

The data in Figure 15 show that the OOHC placement rate in Site C followed a highly nonlinear trend over time. In contrast to Figure 14, quarterly rates of OOHC placement within the sample are not shown due to the small number of cases in the denominator of the proportions for several CSSCs. The vertical dashed line in the graph indicates October 2016 when S&T commenced in Site C. In Site C, after a positive trend in OOHC rates until approximately the first quarter of 2015, the proportion of OOHC placements decreased continuously until the first quarter of 2018 before increasing again until the end of 2018. However, when looking at these data, it is important to note that S&T was implemented among wider responses to DFV across the state and that the additional CSSC was opened in the region in October 2017.

Table 7: Results from regression models, Site C and comparison CSSC

Explanatory variable	Model 1	Model 2	Model 3
S&T	-0.65*	-0.73*	-0.79
	(0.28)	(0.34)	(0.48)
October 2017		-0.56	
		(0.34)	
Constant	0.30	0.30	-0.90 ***
	(0.28)	(0.28)	(0.20)
Additional controls	Yes	Yes	Yes
Number of observations	231	231	475
Log likelihood	-153.69	-153.59	-299.80

Note: Results from logistic regression models. Data extracted from ICMS database. Included are all notifications with recorded investigation and assessment outcome of "substantiated–child in need of protection" in the period April 2014–November 2018. Unit of analysis is notification. Dependent variable is a binary variable taking the value of 1 if at least one child subject to the notification was placed in OOHC during the assessment or up to 180 days after finalisation of assessment. Reported are unstandardised coefficients (log-odds metric). Uncorrected standard errors are shown in parentheses. Models 1 and 2 include data for Site C only. Model 1 is specified as pre-test-post-test design including additional covariates. Model 2 is specified as a three-period design with additional covariates. In this model, the post-intervention period is split into pre- and post-October 2017, when the additional CSSC in the region was opened. Model 3 is specified as a comparison in differences between Site C and the average across comparison CSSCs. For better comparability across CSSCs, the time period for Model 3 is restricted to the period spanning 31 October 2015–1 October 2017. Reported coefficient for S&T for Model 3 is the unstandardised interaction effect in log-odds metric. Additional covariates included in Models 1 to 3 are indicator variables taking the value of 1 if the following criteria are met: 1) at least one child included in the notification is of Aboriginal and/or Torres Strait Islander background; 2) the youngest child recorded in the notification was younger than 2 years at the time of investigation approval; 3) there were four or more children subject to the investigation; and 4) any of the children had earlier intakes in the 12 months prior to the intake approval date. * indicates $p < 0.05$, ** indicates $p < 0.01$, and *** indicates $p < 0.001$.

Table 7 presents the results from regression analyses. Model 1, shown in column 2, specifies the changes from pre-S&T to post-intervention period as a simple change in levels. As one can see from the results, there appeared to be a statistically significant difference in the log-odds of OOHC placement before and after the introduction of S&T in Site C. Unfortunately, the confidence intervals of the estimate are quite large, which is not surprising as the sample includes only 231 notifications. Furthermore, this model averages OOHC placements across the full period after the implementation of S&T. As such, the average also reflects any effects due to the opening of the new CSSC in October 2017.

Model 2 accounts for this additional intervention by splitting the post-S&T period into two phases: 1) 1 October 2016–30 September 2017; and 2) 1 October 2017–30 November 2018. As shown in column 3 of Table 7, accounting for the differences in the post-intervention period increases the association between the early implementation of S&T and the log-odds of placement in OOHC. Unfortunately, splitting the post-intervention period into two phases further reduces the precision of the estimated coefficient, as can be seen from the standard errors in parentheses. This is at least partly due to the small sample size, especially for estimation of the post-intervention means. Overall, a comparison of the AIC and BIC also indicates a preference for the more parsimonious model in column 2 of Table 7, supporting the conclusion that the added complexity to the model is not justified by the gains in model fit.

The last column in Table 7 shows the results for a comparison of the changes in Site C to the average changes across the five comparison CSSCs. To eliminate any possible impacts of the additional CSSC in the region, data included in the analysis were restricted to an evenly spaced period before and after the introduction of S&T. More precisely, only eligible notifications with an assessment approval date between 1 November 2015 and 30 September 2017 were considered.

When comparing the changes in Site C to the changes across comparison CSSCs, the association of S&T with the log-odds of OOHC placement is no longer significant (this holds true also when we express the relationship in the probability metric). Interestingly, any differences observed between Site C and the comparison CSSCs stemmed from differences prior to the introduction of S&T. After October 2016, the trajectories observed in Site C were remarkably close to the developments across the other CSSCs.

SUMMARY OF FINDINGS

Changes in the probability of OOHC placement between the pre- and post-intervention periods in the trial site were observed. However, such changes were not exclusive to the trial site alone as changes were also observed across the comparison sites. As a result, such changes could not be attributed to the implementation of the intervention. It is important to note that the analyses are limited by inadequate sample sizes and pre-existing differences between the trial site and the comparison sites prior to the implementation of S&T in October 2016.

Overall, the evidence presented in this section corroborates the findings from other analyses. While the patterns in the data indicate that there were changes between the pre- and post-intervention periods in Site C, the hypothesis that these were different from the developments across other CSSCs could not be supported. However, two things are important to keep in mind when interpreting these findings. Firstly, the need to control for between-notification correlation for the same children and within-notification correlation for different children subject to the same event substantially reduced the sample sizes. This ultimately impacted on the power of statistical tests and impeded the ability to identify small or moderate changes in the data. Secondly, while the comparison of Site C with other CSSCs provided interesting insights, the time series data warrant caution when interpreting these findings, as included comparison CSSCs were already substantially different from Site C prior to the implementation of S&T in October 2016.

3.5 What are the intersecting complexities of DFV, AOD and MH and how do they relate to children's pathways through the child protection system?

The final research question is focused on the drivers of children's pathways through the child protection system. More precisely, this section aims to shed some light on the complexities surrounding the relationships of I&A outcomes with the co-existence of DFV, AOD and MH within family environments. As a first step, the co-reporting of DFV, AOD and MH was explored. Subsequently, ANOVA type logistic regression models were used to investigate the relationship between the three risk factors and the child protection outcomes described in the previous section.

3.5.1 Data

To investigate the co-reporting patterns between DFV, AOD and MH, the same dataset was employed as was used in graphical analyses of research question 3. This dataset included all notifications with a finalised I&A phase between 1 April 2014 and 31 December 2018 for which a completed family risk evaluation was recorded. As mentioned above, the dataset used for this analysis included 6962 notification-level observations of which 1892 were located in Site C.

The analysis of associations between co-reporting patterns of the three risk factors with planned IPAs and OOHC placements was based on the dataset described in the previous section and, hence, the same limitations apply. In addition, FRE forms were subject to a different extraction process (see Appendix D) which resulted in some of the included notifications having missing data on all factors recorded during family risk evaluation. After reducing the dataset to included complete cases only, 947 notifications were available for the analysis, of which only 218 were located in Site C.

3.5.2 Results

When looking at the patterns in co-reporting of the three risk factors across CSSCs, it is evident that DFV, AOD and MH are most frequently reported together. Table 8 shows the co-reporting of the three factors as a percentage of all recorded FRE forms between 1 April 2014 and 31 December 2018. Overall, notifications with all three risk factors being present were recorded in 17 percent of all FRE forms in the data. Across CSSCs the share of this co-reporting category ranged from 13 percent in Site B to almost 20 percent in Site A. With the exception of Sites A and D, this co-reporting category is the most prevalent across CSSCs.

Table 8: Co-reporting patterns of DFV, AOD and MH as a percentage of recorded FRE forms

Risk combination	Site A	Site B	Site C	Site D	Site E	Site F	Total
DFV only	4.1%	8.6%	4.5%	7.4%	4.3%	5.7%	5.6%
MH only	11.0%	12.7%	11.6%	7.6%	9.5%	11.1%	10.8%
AOD only	12.1%	12.0%	11.3%	18.1%	13.2%	12.8%	12.9%
DFV + AOD	8.4%	7.1%	10.0%	12.8%	10.6%	10.5%	9.9%
DFV + MH	3.4%	4.5%	3.4%	3.3%	3.7%	4.9%	3.9%
MH + AOD	21.8%	12.3%	17.1%	13.6%	15.0%	16.0%	16.0%
DFV + AOD + MH	19.6%	13.0%	17.9%	14.1%	17.3%	18.3%	16.9%

Note: Included are all notifications with a completed I&A phase between 1 April 2014 and 31 December 2018 and an available FRE form. Columns show how often a particular pattern was reported in a given CSSC, as a percentage of all recorded FRE forms in that CSSC. Column totals may not add to 100% as FREs without any of these risk factors present are excluded from the table.

The second most frequently observed combination of these three risk factors is MH reported together with AOD but no DFV. This category accounts for 16 percent of all included notifications. Overall, the data presented in Table 8 highlight that DFV is more likely to be reported in combination with either AOD (9.9%) or AOD and MH (16.9%). In contrast, among the available notifications with non-missing FRE forms, co-reporting of DFV with MH only was least likely to be observed among these co-reporting patterns (3.9%).

Figure 16 further disaggregates the co-reporting patterns for DFV with the other two factors by quarter of I&A completion between 1 April 2014 and 31 December 2018. To avoid cluttering in the graph, co-reporting of DFV with only one of the other risk factors was consolidated into a single category.

For Site C, Site A, Site D and Site E, the share of co-reporting of all three risk factors has increased over time. Again, reporting of DFV without the presence of AOD or MH is the least likely observed co-reporting pattern during most quarters across CSSCs. Interestingly, the share of notifications with all three risk factors recorded increased substantially following the introduction of S&T in Site C. However, based on the available data it is not possible to tell whether S&T contributed to these changes, especially when contrasting the time series of Site C to other CSSCs like Site E, Site D or Site A.

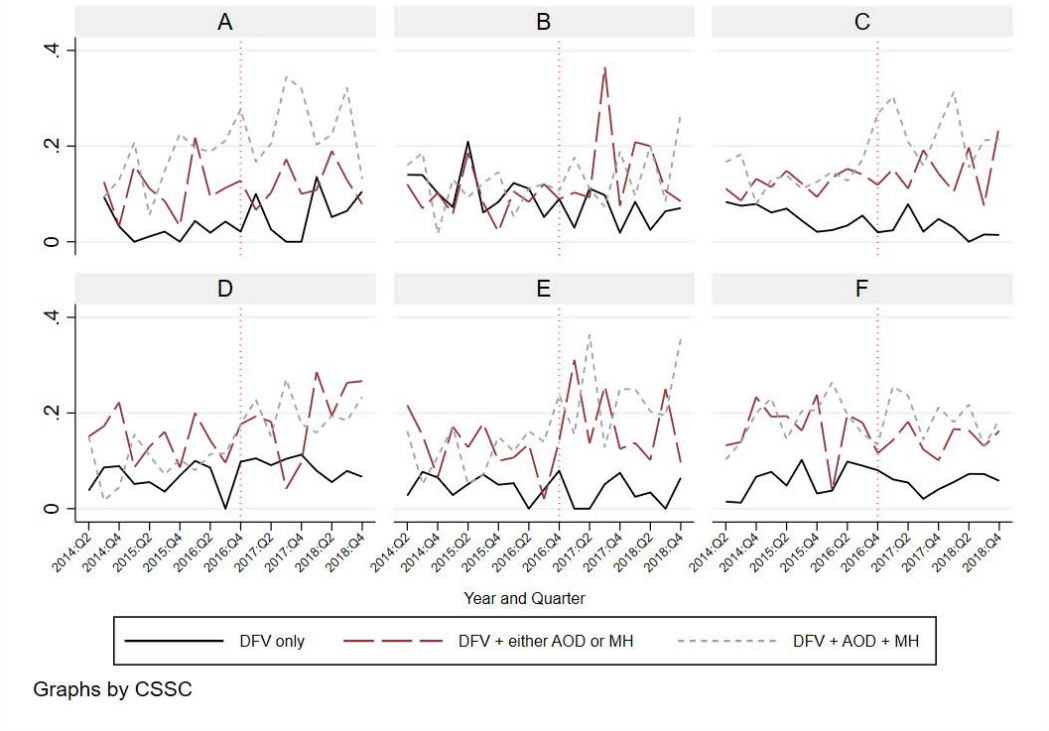
So far this analysis has only focused on the direct associations of DFV with AOD and MH and has not considered any complex relationships between DFV and other risk factors assessed during the FRE process. However, it is important to note that in the vast majority of FRE forms with indicated DFV, at least one of the two other risk factors is also indicated (84.5%). In Site C this ratio is even higher with 87 percent of all FRE forms reporting at least one of the two additional risk factors in addition to DFV. From a practice perspective, it is of interest to further investigate the pathways through which these constructs are related.

One way of assessing relationships between binary variables is to estimate the tetrachoric correlations, which is equivalent to a bivariate analysis using Pearson correlation coefficients for continuous variables.[10] However, as this study is interested in the complex interactions between DFV and other risk factors, FRE items were analysed using the CIT method (see "Knowledge translation box 2") introduced by Hothorn et al. (2006). CIT estimates relationships between variables by repeatedly splitting subsets of data into smaller subsets until no statistically significant relationship can be identified. While this approach is generally used for classification and prediction, here it is used to identify possible structures of relationships within the given set of FRE forms.

Figure 17 illustrates the results for this recursive partitioning algorithm based on a pooled dataset for all CSSCs. The algorithm identified 11 different combinations of risk factors in the data. The strongest predictor of DFV among the included indicators was AOD, which is shown by this indicator being the first split variable. From there onwards different risk factor profiles can be identified by following the different

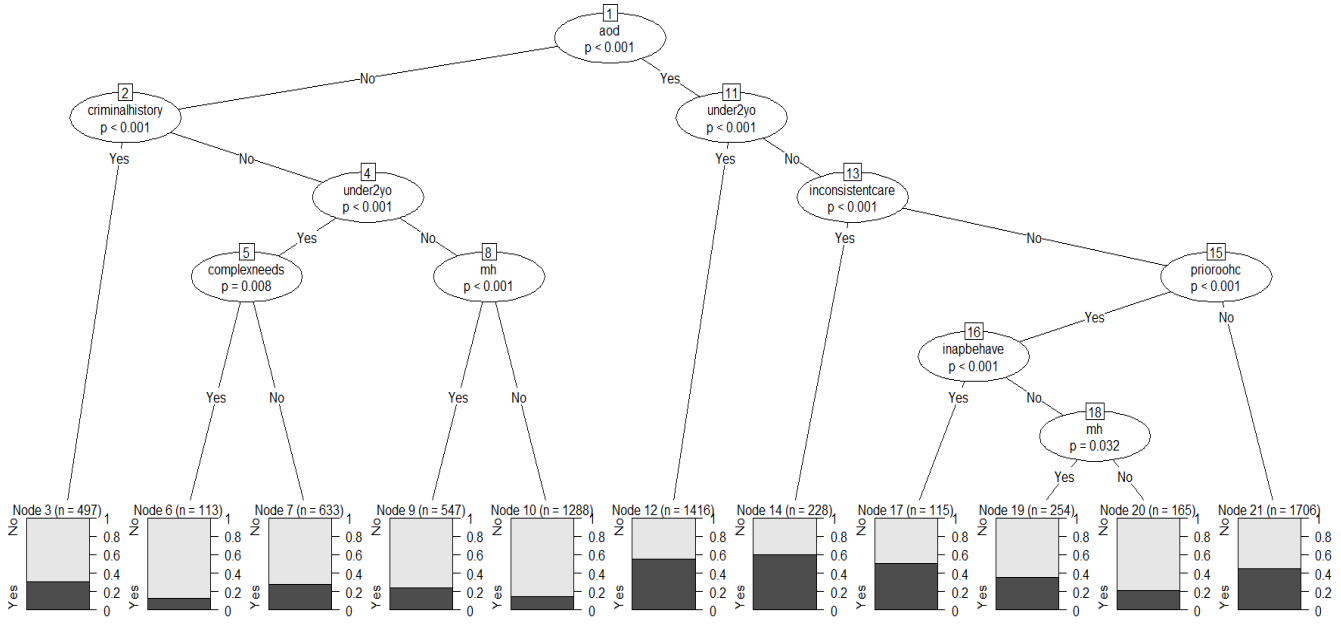
10 For continuous variables the Pearson correlation coefficient measures the strength of association and is widely applied in pairwise (or bivariate) analyses of variables. The tetrachoric correlation coefficient estimates the strength of association between two binary variables. The calculation is technically complex and we refer the interested reader to the literature on analysis of categorical variables (e.g. Drasgow, 1986).

Figure 16: Co-reporting patterns of DFV with AOD and MH by CSSC, 1 April 2014–31 December 2018



Note: Included are all notifications with a completed I&A phase between 1 April 2014 and 31 December 2018 and an available FRE form. The vertical red dotted line indicates the date when S&T was introduced in Site C. Vertical axes show the proportion of notifications with respective combinations of risk factors for each quarter within a particular site.

Figure 17: Relationship structures of FRE items based on recursive partitioning, all CSSCs



Note: Graph shows conditional inference tree based on recursive partitioning (Hothorn et al., 2006). Risk profiles are identified by following the pathways from top to bottom. Probability of DFV indicator taking value of 1 (i.e. DFV present) is shown in bar chart of final node. Variables shown are: alcohol and other drugs (aod); caretaker criminal history (criminalhistory); at least one child is under the age of 2 (under2yo); care inconsistent with child needs (inconsistentcare); children have complex needs (complexneeds); mental health (mh); prior OOHC recorded (prioroohc); inappropriate parental behaviour (inapbehave). Splitting was based on Bonferroni adjusted p-values from permutation test statistics.

KNOWLEDGE TRANSLATION BOX 5: INTERPRETING RESULTS FROM FIGURE 17

As described in "Knowledge translation box 2" and in previous paragraphs, the CIT method segments the data by repeatedly splitting the sample into non-overlapping regions. The results from this approach can be presented in a tree-like graph that is easy to interpret.

Beginning from the top of the graph, the data are split into two groups, one where alcohol and other drugs (aod) was identified and one without this risk factor present. Applying the splitting algorithm again within each subset results in four pathways originating from the two groups. Each pathway from the top to the bottom of the graph describes a particular combination of risk factors.

At the bottom of the tree are the final categories. For each category, a box shows the proportion of cases with DFV identified within the category. Overall, we can see that there were several "low risk of DFV" groups identified, where the proportion of identified DFV was much less than 0.5 (or 50%). However, no combination of risk factors provided a strong predictive configuration of DFV.

pathways in the graph. For each combination of risk factors, the probability of DFV being indicated for the notification is shown in the final node at the bottom of the graph. The results indicate only two profiles that are associated with elevated indication of DFV: 1) AOD in the presence of children under the age of 2; and 2) AOD combined with care that is inconsistent with the needs of the children, if no children under the age of 2 are present in the household.

While these findings indicate some interesting relationships between the different items recorded in the FRE forms, they need to be interpreted with care, as including different indicators in the set of variables may change the identified relationship structures, similar to the case of descriptive regression analyses. One result which strengthens the conclusion of a strong relationship between DFV and AOD is that the latter variable is identified as the strongest predictor in every CSSC when conducting CSSC-specific sensitivity analyses (available from authors upon request).

Following the investigation of relationships between risk factors and DFV, the focus of the analysis shifts towards the associations of DFV, AOD and MH with children's pathways through the child protection process in Queensland.

Given the restrictions imposed by the data, this analysis will be based on the sample used to investigate research question 4, minus notifications for which no FRE information was available in the data. To investigate whether DFV, AOD, MH and combinations thereof are related to child protection outcomes, regression models were used. More precisely, the binary outcome variables defined for research question 4 were regressed on indicator variables for DFV, AOD and MH as well as a full set of interaction terms. Such a model can be considered as a nonparametric model to assess differences in probabilities between different categories of risk factor combinations (see Harrell Jr., 2015). However, none of the results from these models indicate a statistically significant relationship between DFV, AOD or MH with child protection outcomes and the results are available from the authors upon request.

SUMMARY OF FINDINGS

DFV was most commonly co-reported with other risk factors, especially both AOD and MH, across sites. AOD was the strongest predictor of DFV in the data. However, the analyses did not identify statistically significant relationships between DFV, AOD or MH with child protection outcomes.

3.6 What is the evidence for the early impacts of Safe & Together on the child protection system?

This study provides an exploratory investigation of the implementation of the S&T Model in Site C and the possible early effects this program may have had on the wider child protection system in Site C (Queensland). More precisely, this study intended to answer the following research questions:

3. Have there been higher rates of DFV identified in the trial site following the introduction of Safe & Together compared to comparison areas?
4. How have children's and families' post-substantiation child protection outcomes changed since the implementation of a DFV-informed S&T approach to child protection?
5. What are the intersecting complexities of DFV, AOD and MH and how do they relate to children's pathways through the child protection system?

In addition to these research questions, this study was also a pilot exploratory study to assess the feasibility of a larger scale investigation into the effects of the implementation of S&T within child protection systems in Australia.

The results from the analyses presented in this report do provide some evidence that the introduction of a DFV-informed approach was associated with changes in the child protection process in Site C. However, it is not clear from the data if, and to what extent, the intervention itself contributed to these changes as competing causal explanations could not be ruled out. Furthermore, the opening of an additional CSSC in the region 12 months after the introduction of S&T may have resulted in conflated patterns observed in the data. However, this would only affect associations between S&T and DFV identification in the medium term after October 2017, and does not explain the early changes in systems behaviour indicated by the data based on graphical analyses. To some extent, a possible explanation of the observed relationships could also be anticipation effects on staff in Site C or contemporaneous interventions following the release of the *Not Now, Not Ever* report (Queensland. Special Taskforce on Domestic and Family Violence in Queensland, 2015). While the former explanation could not be supported by statistical analyses using the available data for Site C, the latter was assessed by comparing developments in Site C with other CSSCs in Queensland. This comparison could not reject the hypothesis that other centres in Queensland experienced similar differences in the reporting of DFV over this period. Overall, while some patterns in the data were pointing to a positive development in the identification of DFV following the introduction of S&T, these findings must be considered in light of the limitations of this study as explained in the next section.

Whether any effects of S&T on children's trajectories through the child protection system could be identified was investigated by analysing two constructs derived from the data. First, IPAs were assessed by looking at changes in the likelihood of an IPA being the planned intervention at the end of the I&A phase for children who were in need of protection. Graphical analyses showed strongly nonlinear patterns in the data over time and vastly different trends in planned IPAs across CSSCs. Overall, these patterns made it difficult to identify any effects that could be attributed to S&T in Site C. As a consequence, the statistical analysis was not able to confirm any changes in the rates of planned IPAs as a result of a DFV-informed child protection approach in Site C. However, graphical analyses point to substantial shifts in I&A outcomes towards an increase in planned IPAs, at least in the first 12 months following the intervention.

In addition to planned interventions with parental agreement, the relationship between S&T and OOHC placement for children in need of protection was investigated. Here, within-site (Site C) analyses estimated substantial decreases in the probability of being placed in OOHC over time. Graphical analyses, however, indicate that these trends had commenced prior to the introduction of S&T and a comparative analysis could not reject the hypothesis that the changes observed in Site C were significantly different from the average developments across other CSSCs. Again, limitations of the analysis have

to be considered in this context, especially the lack of an untreated comparison site to represent the trend of OOHC placements in Site C in the absence of an intervention.

The final research question focused on the relationships among reported DFV, AOD and MH for families involved with the child protection system. The analysis of available family risk evaluations showed that DFV was most often reported in combination with other risk factors. In particular, the co-reporting of DFV with both AOD and MH was the most prevalent pattern across CSSCs. Graphical analyses indicated that the reporting of all three risk factors in Site C, as a proportion of all family risk evaluations, increased substantially after October 2016. Further analyses into the relationships of DFV with the two other risk factors revealed that these associations are based on complex profiles that also involve other family risk factors. However, when assessing the relationship of DFV, AOD and MH to child protection outcomes, none of the specified models were able to show a statistically significant relationship between DFV, AOD, MH and combinations thereof. Again, the limitations in the data and related low statistical power may have impacted those analyses.

3.6.1 Limitations of this study

As mentioned on several occasions, this study was subject to some limitations that are likely to have impacted its ability to fully investigate the extent of relationships between S&T and the outcomes of interest.

The most obvious limitation of this study is the absence of S&T-specific data in the ICMS extracts. Without this information it was not possible to identify notifications where DFV-informed child protection processes would have been directly applied. As such, this study was focused on the wider impacts of the introduction of S&T on the child protection system in Site C and not on the direct effects of the intervention on outcomes for children.

One of the most challenging obstacles was the reliance on data extracts generated for annual government reporting. These datasets are generally not intended for longitudinal analyses but rather for monitoring of systems outputs within a given reference period. Despite close collaboration and substantial support from the QDCSYW, it was not possible to generate a full extract from the ICMS within required timelines and therefore the analysis had to rely on available reporting extracts. As explained in earlier sections and Appendix E, this is very likely to have introduced selection effects, which in turn lead to decreased sample sizes and may have resulted in a non-representative sample of the overall population of children recorded in the ICMS between April 2013 and March 2019. Furthermore, the unavailability of CSSC-specific information prevented the consideration of confounding factors in the analytical models which further rendered causal conclusions impossible. This has to be considered when reading the results, and findings should be interpreted within the included sample only. Finally, the limitations in the data also affected the analytical approach itself. While it would have been desirable to employ more substantive models to investigate the outcomes of interest, the limitations in the available data and the resulting small sample sizes did not allow such analyses.

Another consequence of using reporting data was that some important information was not available in the extracts. This included some measures of outcomes or related indicators. For example, the unavailability of the full child protection history for children included in the analysis posed challenges to the interpretation of re-notifications in the data. Together with other limitations resulting from the complexity of the child protection system during this period, the authors were unable to produce a reliable and interpretable measure of re-notifications and this stream of analysis had to be excluded from the study.

As mentioned during the discussion of research question 3, the analysis of DFV identification patterns as presented in this report is subject to several limitations. Firstly, the FRE form data by themselves are only part of the information needed to fully investigate this question. This is because FRE items reflect two sources of information: 1) possible presence/absence of DFV within the household; and 2) the practice behaviour and identification of DFV by the Child Safety Officer (CSO). Without further information about practice changes or other indicators of DFV presence in the household, it is not possible to disentangle the two sources

of information. In other words, it is not possible to conclude from the data whether the change (or absence of a change) was due to practice changes or due to a change in true prevalence of DFV over time in Site C.

Unfortunately, limitations in data availability also affected the choice of surrogate measures for IPAs and OOHC placements as explained in the previous sections. As such, the imperfect relationship between the employed indicators and the true outcomes for children may have diluted the identified relationships between S&T and the outcome measures. Furthermore, if these proxy outcomes are not reliable representations of actual IPA and OOHC placements, then the relationships shown in the results of this study may not reflect the true associations between the introduction of S&T and children's pathways through the child protection system.

The actual dissemination of S&T in Site C was indirect, where several champions from child protection were trained in DFV-informed approaches and then were expected to disseminate these approaches throughout the CSSC. Therefore, the actual uptake of the intervention may have been increasing over time, which would have had negative effects on the identifiability of the impacts of S&T on child protection outcomes. This is especially critical if the full effects of the S&T approach in Site C co-occurred with competing system interventions such as the opening of the additional CSSC in October 2017.

Finally, from an analytical point of view, the decision to focus on only one treated centre impacted the statistical designs and consequently statistical inference. Also, the often large differences between Site C and comparison CSSCs during the period preceding the introduction of S&T substantially impacts the interpretation of the observed effects. This needs to be considered in addition to the possibility that comparison centres were likely also subject to different interventions during the same period as part of wider responses to DFV across the state.

Nevertheless, despite these shortcomings, several of the findings indicate positive changes that may be related to the availability of S&T in Site C and it is important to note that most of the challenges experienced in this study were due to its explorative nature and short project timelines. As such, these conflicts can mostly be resolved, and future studies can benefit from this pilot study by addressing the limitations discussed above.

3.6.2 Conclusion

Overall, the findings from this study show inconclusive results. Graphical analyses generally pointed to positive associations of S&T with investigated changes in outcomes in Site C and this was in some cases supported by statistical models. However, comparative analyses showed that similar developments could be observed in other CSSCs. This by itself does not invalidate the positive associations of S&T, as at least some of the comparison CSSCs are likely to also have been subject to interventions over the same period. Therefore, the trends observed in available comparison centres are most likely not a good projection of the trend in outcomes that would have occurred in Site C without the introduction of S&T. The fact that most models in the analysis showed associations of S&T with outcomes in the expected direction is encouraging, although point estimates of relationships were generally imprecise.

Besides being the first quantitative systems-level analysis of an implementation of the S&T Model in Australia, this study made some substantial practical contributions. Most importantly, this research team has demonstrated that ICMS data can be used to generate longitudinal datasets by developing an algorithm to link individual components from the ICMS with SDM data. This data structure can be further extended to include additional components from ICMS to address the limitations described above. Moreover, as part of this analysis, the research team was able to generate a gap map highlighting additional information that needs to be extracted from ICMS as well as other data sources in order to enable a full evaluation of S&T and comparable interventions.

In conclusion, the findings from this study call for more comprehensive investigations into the effects of implementing DFV-informed child protection processes in Australia. The results presented here point to some interesting effects of S&T that should be explored in detail. However, in order to

do so, a future investigation should address the limitations described in the previous section, which may be achieved through one or more of the following recommendations.

1. A cohort-based study design at the child-notification level

Given the indirect dissemination of S&T in Site C and the ongoing state-wide changes in the child protection system, it is difficult to attribute any observed patterns directly to S&T. Hence, it is recommended that a comprehensive evaluation of this intervention be conducted at the child-notification level using a cohort design to enable researchers to control for the history of children's involvement with the child protection system.

2. Study-specific data extracts including additional items from ICMS and extended periods of observation

To investigate the impacts of S&T on child protection practice and outcomes for children, it is important to use a dataset specifically tailored to the focus of the study. Such an extract would include a series of additional items from the ICMS including the safety assessment information and case planning data. Most importantly, improved outcome measures should be included such as IPA data and information on applications for court orders. A study-specific extract would eliminate a substantial portion of the missing data patterns observed in the current analysis. This would also lead to increased sample sizes and eliminate sample selection concerns. Extended observation periods, dating back for as many years as possible, would allow controlling for family history of child protection involvement in a cohort study design. Furthermore, this information could be used to establish measures of family relationships across notifications, which would substantially improve the analytical design.

One of the most crucial improvements to the dataset would be the inclusion of CSO information in the ICMS extracts. In the current study it was not possible to identify notifications that actively involved CSOs who were specially trained in the DFV-informed child protection approach. Adding such data would enable a direct within-site (Site C) comparison of intervention versus non-intervention notifications. To be more precise, it would enable an evaluation of the direct impacts of S&T on child protection outcomes in Site C. Furthermore, a within-site comparison group may allow researchers to better differentiate between Site C-specific effects and S&T-specific effects, which was not possible using the available data extracts.

3. Linking additional data to the ICMS extracts

In order to improve the quality of the analytical designs, it is recommended that additional data are included in the analysis. For example, information collected as part of the S&T intervention may add substantial value to the analysis. Furthermore, adding CSSC-specific data, such as staff numbers, per-capita caseloads, and competing programs being implemented, would provide crucial information that would help eliminate potentially competing causes from the patterns in the data.

4. Expanding the analysis to include additional treatment groups and comparison centres

A shortcoming in the current study was the availability of only a single treatment group. In order to improve analytical designs to assess the impacts of S&T, the evaluation could be expanded to include additional sites where S&T was introduced. This approach would substantially add to the statistical models and improve statistical inference.

The inclusion of additional comparison centres would increase the probability of finding suitable comparators for the analysis. The lack of non-intervention comparison centres limited the comparative analyses presented in this study and could potentially be addressed by expanding the sample to include additional sites. Most importantly, the inclusion of additional centres and time points, in combination with study-specific data extracts, would enable researchers to explore alternative analytical designs such as synthetic control methods (Abadie et al., 2010). In the current study, these approaches were abandoned as no suitable synthetic control group could be generated.

CHAPTER 4:

Synthesis of findings and discussion of their implications

The STACY for Children project explored five research questions using a mixed methodology which included two distinct studies: Study 1, "Listening to the voices of people working and living at the intersection of domestic and family violence, alcohol and other drugs and mental health"; and Study 2, "Exploratory quantitative analyses of the wider impact of Safe & Together in an intervention region". Together, the studies explored different perspectives on working at the intersection of DFV, AOD and MH services in areas or organisations in which workers had experienced S&T training, coaching and supervision.

The mixed methods approach was used to ensure that we had interviews and stories from those whose lives had been impacted by DFV and MH and/or AOD, as well as from workers who had experienced S&T training through the STACY project. In this project, we were particularly interested to understand how children were kept in view, and this involved a secondary analysis of much of the data collected in the original STACY project. We were then interested to know whether there had been any flow-on effect which showed in the child protection database in an area where there had been a focus on S&T training, supervision and coaching.

Each study provides its own research discussion. In this section, we summarise some key findings as well as looking across the implications for practice, policy and research.

4.1 Drawing from the literature

The critical interpretive synthesis of the literature regarding the intersection of DFV with AOD and MH issues drew attention to the problematic silos in the service system that tend to isolate one problem from another, rather than recognising the ways in which these issues intersect (Isobe et al., 2020). Forty papers were reviewed to address the question: how does research into the intersection of DFV with MH and AOD inform practice with children and families? Three mutually reinforcing themes emerged from the analysis of the literature:

- problematic differences in theoretical approaches and client focus
- complexity of systems' collaboration when the service sector is siloed
- practices converging on mothers, and ignoring men as fathers and the impact of fathers, DFV and/or AOD and MH issues on the children and the functioning of the family.

The analysis of the literature took the discussion beyond the simple recognition of the co-occurrence of the "toxic trio" of problems to explore whether and how workers addressed the intersection of these issues—in particular, the ways in which the perpetrator of DFV could be kept in view. This included the ways in which either his MH and AOD use problems were used to "cover" the use of violence and abuse, or alternatively how MH and/or AOD use issues were recognised and related to the context of abuse in which the woman and children were living. Lack of recognition of adult clients as parents and the needs of children within traditionally adult services (MH, AOD and to a lesser extent DFV) were consistently highlighted as gaps in the service system (Blythe et al., 2010).

Interestingly, however, there were some indications of progressive and emerging developments. These developments included the voices of those with lived experience in the area of DFV and AOD (Galvani, 2015; Templeton et al., 2009). In the AOD use area, there were also a small number of programs identified that supported mothers who were DFV victims/survivors with AOD issues (Tsantefski et al., 2015). Also included were examples of programs that were addressing the intersection of AOD issues for fathers who perpetrated DFV, which showed that when these issues were addressed together there was much stronger improvement against a wide range of measures when compared with a single-issue focus (Stover, 2013; Stover et al., 2017).

The involvement of services, particularly statutory child protection, was often triggered by DFV in conjunction with AOD or MH issues in either or both parents. However, it was notable that as the focus on risk to children increased, the attention to the issues of the mother's needs and wellbeing diminished and the shift to monitoring and assessment of her parenting increased (Frederico et al., 2014; Radcliffe & Gilchrist, 2016; Sidebotham & Retzer, 2018). There was

little evidence of children's needs being addressed at the intersection of DFV, AOD and MH, though there was some attention emerging for services to address all family members affected by DFV, some of which was occurring in the context of AOD and MH issues (Templeton et al., 2009). It is against this backdrop that the STACY for Children project was designed and where key findings, implications and recommendations are situated.

4.2 Key findings and implications for practice

Across the two studies, the impact of S&T training, coaching and supervision on practitioners and clients indicated positive directions for practice. Clients who were interviewed were able to identify positive differences in approach between workers who had been trained in S&T and their previous workers.

In the practice arena, there are a number of positive indicators of change associated with DFV-informed practice using the S&T Model. These include:

- a focus on the perpetrator of violence, including his role as a father
- partnering with women to identify strengths and protective strategies which support their relationships with their children
- recognising children in their own right, and specifically the harm created by the perpetrator of DFV
- understanding the intersection of the tactics of abuse and violence with MH and AOD issues (Healey, Humphreys, et al., 2018).

Study 2 used indirect indicators from an analysis of the child protection administrative database to highlight shifts in practice that may be consistent with S&T Model impacts. These include greater reporting of DFV, use of planned IPAs, and a decrease in OOHC placements.

Data drawn from both family member interviews and consultations with professionals indicate that the practice of workers trained in S&T, and coached in implementing the S&T Model, increasingly recognised the importance of assessing children, parenting and family functioning in any DFV intervention. Practitioners reported practice developments to increase the visibility of children through engaging fathers about the impact of their behaviour on their relationships with their children; assessment of the impact on parenting of DFV, AOD or MH issues; or direct engagement with children about their experiences. In particular, both clients and practitioners spoke of the value of the S&T tools, such as the perpetrator mapping tool, to guide and focus constructive, DFV-informed conversations that improved DFV literacy.

Clients and practitioners both highlighted the value of the focus on all family members—children, mothers and fathers—as well as addressing the issues for victims/survivors and taking steps towards ending the perpetration of abuse. Both mothers and children spoke about workers who they appreciated had taken time to focus on the needs of the child, but the more general finding was that children were not spoken to, particularly in relation to legal decisions that profoundly impacted their lives. The direct involvement of children was not common practice in AOD and MH services and practitioners in these services spoke of the "awkward fit" of a model that focused on keeping DFV in view, raising issues about children and focusing on the adults as parents. Throughout the data, keeping a direct focus on children was given less attention by practitioners than engagement with fathers or partnering with mothers.

In Study 2, the co-reporting of DFV with both AOD and MH was the most prevalent reporting pattern across CSSCs. Graphical analyses indicated that the reporting of all three risk factors in Site C, as a proportion of all FREs, increased substantially after the introduction of S&T in October 2016. Further analyses into the relationships of DFV with the two other risk factors revealed that these associations are based on complex profiles that also involve other family risk factors.

The implications of these findings for practice need to be read in conjunction with the discussion on implications for policy. An artificial distinction has been made, given that policy and practice initiatives interact with each other, and the development of policy and practice derives from both practice expertise and managerial support and leadership.

RECOMMENDATION 1

The S&T Model continues to be further explored with practitioners across different sectors to ensure a more ethical and DFV-informed approach to practice. In particular, continued peer support and engagement through CoPs across sectors would enable cross-sector sharing of practice expertise to inform both policy and practice.

The co-occurrence of DFV, AOD and MH within families where there is DFV is confirmed in the analysis of Australian child protection data (Australian Institute of Health and Welfare, 2020) and should be reflected in the training, supervision and coaching of practitioners across different sectors (Frederico et al., 2014). In particular, the strategies for keeping the perpetrator of DFV in view, and understanding the ways in which AOD and MH issues are used as part of the wider tactics of coercive control, require training and focus. Doing so will embed practice that moves beyond identifying the co-occurrence of these issues towards an understanding of how they are intersecting and connected (Isobe et al., 2020).

RECOMMENDATION 2

The co-occurrence and interconnections between DFV, MH and AOD are incorporated into the training, supervision and coaching of practitioners across all relevant sectors.

Children are continuously lost from view in the different parts of the service system, particularly, but not only, in adult-focused services. Throughout the study, keeping a direct focus on children was given less attention by practitioners than engagement with fathers or partnering with mothers.

RECOMMENDATION 3

Increased attention and focus is given to strategies, programs and resources that recognise adults as parents and enhance visibility of their children in DFV, AOD and MH interventions.

4.3 Key findings and implications for policy

The need for system-wide changes is highlighted as a key finding and a complex area to address. It confirms the direction promoted by Priority Five of the *National Plan to Reduce Violence against Women and their Children 2010–2022 (Fourth Action Plan)*, which identifies the need to improve support and service system responses by enabling cross-sector collaboration and responsiveness (Commonwealth of Australia. Department of Social Services, 2019). Practitioners involved in implementing the S&T Model reported their direct practice to be moving ahead of that of their organisations, in relation to creating visibility of children, holding a focus on adult clients as parents, and keeping all family members in view around tactics of coercion and control.

RECOMMENDATION 4

Senior managers in MH, AOD and DFV organisations proactively develop policies for their staff to facilitate conversations about the role of their clients as mothers and fathers and how to increase the visibility of children.

A significant policy issue arises from this study about the way in which senior managers in organisations can provide practice and procedural guidance to practitioners to allow them to move beyond a single issue/single adult focus to address the intersections between DFV, AOD and MH and recognise their clients as parents with responsibilities and accountability to other family members.

RECOMMENDATION 5

Senior managers in MH, AOD, child protection and family service organisations develop protocols, following the STACY project Practice Guides (Heward-Belle et al., 2020), that address the intersection of DFV with other complex issues challenging the families seen in their organisations.

Another key area for further policy development is child-focused work. In the CoP discussions there were only a few examples of practitioners working directly with children, even in child-focused and family organisations, and this is

an area where further development is needed. Children and their mothers highlighted their positive experiences of direct work with children when this occurred. Similarly, service experiences where practitioners identified the strengths of women supporting their children through the challenges of DFV were also received particularly positively and contrasted with other interventions where mothers found themselves "under surveillance".

RECOMMENDATION 6

Senior managers in MH, AOD and DFV organisations:

- facilitate the training of a group of practitioners in their organisation to be children's specialists, working directly with children to understand their perspectives, *or*
- employ a specialist worker who can provide appropriate secondary consultation about children in the organisation.

In adult-focused services, this will potentially involve the specialised development of brief counselling formats or assessment processes with a focus on children.

RECOMMENDATION 7

Sector leaders and agency managers adopt a policy position that keeps children safely with their mothers as the default starting point for practitioners in their agencies. This recognises the importance of supporting the relationship between non-offending parents (usually mothers) and their children.

The lack of mental health services for children was a particular concern raised by women and practitioners, who recognised the trauma that many children were carrying that was impacting on their behaviour and development.

RECOMMENDATION 8

The serious lack of mental health services for children and young people living with DFV, highlighted as a service gap, is urgently addressed.

4.4 Key findings and implications for research

4.4.1 Study 1

This research has highlighted the importance of hearing from those with lived experience of the service system where there are issues of DFV and MH and/or AOD. Their stories are compelling. Similarly, hearing from practitioners about their experiences of the challenges and the importance of working with DFV where there are further issues of MH and AOD enhanced the depth of our understanding in this area. In particular, the issues of keeping children in view were highlighted in this study.

However, the study also highlighted gaps and the need for further research. In particular, we note that only five children were able to be interviewed. Part of the invisibility of young people and children within the service system revolves around the difficulty in directly hearing their voices and their experiences of the service system. This is unsurprising. Great care needs to be taken to ensure that there is reciprocity and engagement that might hold some direct benefits to the young people involved (see Lamb et al., 2018) and that children are not re-traumatised. They do, however, have a right to participation and to be heard.

RECOMMENDATION 9

A project titled STACY *with* Children rather than STACY *for* Children be undertaken as an important further step in the exploration of the experiences of children and young people who are involved in the service system where there are intersecting issues of DFV and MH and/or AOD. As in previous projects, workers trained in working with the S&T Model would be engaged in the research.

There were other voices that were notably absent in this research, including those from culturally and linguistically diverse backgrounds. In particular, the direct experiences of Aboriginal and Torres Strait Islander children, mothers and fathers are missing. Given the over-representation of Aboriginal and Torres Strait Islander children in the child protection system this is a significant absence that needs to be addressed.

RECOMMENDATION 10

An Aboriginal and Torres Strait Islander-led project is undertaken, which explores holistic approaches to children, women and men where there is DFV and intersecting issues of MH and AOD. This could include the development of practice tools that are co-designed by and customised for Aboriginal and Torres Strait Islander families and their communities, and potentially informed by the S&T Model and its resources.

4.4.2 Study 2

The pilot study undertaken using the analysis of a state child protection administrative database highlighted the challenges in using, but also the potential use of, big data to understand trends and to ask pertinent research questions of the data. The data analysts on this project demonstrated the ability to "clean" the data to make a longitudinal dataset and to create linkages between different parts of recorded practice. They demonstrated that ICMS data can be used to generate longitudinal datasets by developing an algorithm to link individual components from the ICMS with SDM data. Moreover, as part of this analysis, the research team was able to generate a gap map highlighting additional information that needs to be extracted from ICMS as well as other data sources in order to enable a full evaluation of S&T and comparable interventions.

The results of this pilot study point to some interesting changes following the implementation of S&T. However, as is outlined in detail throughout the report, Study 2 was subject to several limitations that restricted its ability to fully investigate the effects of the DFV-informed child protection intervention in the trial area. Nevertheless, these limitations could largely be addressed through research question-specific study designs and data extracts. These points are outlined in the following recommendation.

RECOMMENDATION 11

Future research on the impacts of S&T on child protection practice and outcomes for children include the following initiatives:

- a cohort-based study design at the child-notification level
- development of a dataset specifically tailored to the focus of the study, including additional items from the ICMS and extended periods of observation
- linking of additional information to data extracted from the ICMS
- expansion of the analysis to include multiple treatment groups and comparison centres.

A targeted research design will enable more comprehensive investigations into the effects of S&T on child protection practice, and consequently, the pathways of children and families through the statutory child protection process. Moreover, such a study could provide new learning into the interactions between risk factors and their relations to DFV in Australia.

CHAPTER 5

Conclusions

The two studies that constituted the STACY for Children project have brought different perspectives to the issues under consideration. Study 1 has enabled the researchers to examine in detail the thoughts and experiences of both professionals and family members with lived experience in relation to DFV-informed, child-focused practice. The CoP model methodology for capacity-building DFV-informed practice has supported and recorded emerging and very positive practice in this complex area.

Study 2, through an analysis of the administrative child protection database, indicated interesting changes in a positive direction following the implementation of S&T. The limitations encountered by this study have enabled researchers to set out clearly what is needed for further analysis if the administrative database is to more accurately link practice developments to changes in child protection data.

Bringing the findings of the two studies together, the STACY for Children project points the way to further research and practice development in building a greater child focus and engagement into DFV-informed practice across a number of services, highlighting the intersections in particular with MH and AOD services.

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APPENDIX A:

DFV-informed continuum of practice exercise

Name: _____

This exercise is based on the Domestic Violence-Informed Continuum of Practice, developed by the Safe & Together Institute. You can refer to the full Domestic Violence-Informed Continuum of Practice document provided, also on page 18 of the Safe & Together Intersections Training Participant Guide.

Thinking about policy, practice, training, services and collaboration related to intersections, please rate the **current practice** of your organisation/team/program between a weak nexus/domestic violence destructive practice` and a strong nexus/domestic violence proficient practice. Tick a box on each row along the continuum.

Current practice of my organisation/team/program						
Weak nexus	1 Domestic violence destructive	2 Domestic violence neglectful	3 Domestic violence pre-competent	4 Domestic violence competent	5 Domestic violence proficient	Strong nexus
About the adults	☐	☐	☐	☐	☐	*Integrated with children/other CP issues*
"Failure to protect"	☐	☐	☐	☐	☐	*Perpetrator pattern*
Fathers invisible	☐	☐	☐	☐	☐	*High standards for fathers*
Child v. adult survivor	☐	☐	☐	☐	☐	*Child safety and wellbeing tied to adult survivor*

Have a look at how you rated your organisation's practice at the end of the three days of S&T training. Regardless of whether it is similar or different, can you now **re-plot where you think this practice was** before you started the STACY project?

My organisation's practice at the beginning of the STACY project						
Weak nexus	1 Domestic violence destructive	2 Domestic violence neglectful	3 Domestic violence pre-competent	4 Domestic violence competent	5 Domestic violence proficient	Strong nexus
About the adults	☐	☐	☐	☐	☐	*Integrated with children/other CP issues*
"Failure to protect"	☐	☐	☐	☐	☐	*Perpetrator pattern*
Fathers invisible	☐	☐	☐	☐	☐	*High standards for fathers*
Child v. adult survivor	☐	☐	☐	☐	☐	*Child safety and wellbeing tied to adult survivor*

Now think about your ways of working as an individual practitioner. Please rate **your own current practice in relation to intersections.**

My current practice						
Weak nexus	1 Domestic violence destructive	2 Domestic violence neglectful	3 Domestic violence pre-competent	4 Domestic violence competent	5 Domestic violence proficient	Strong nexus
About the adults	☐	☐	☐	☐	☐	*Integrated with children/other CP issues*
"Failure to protect"	☐	☐	☐	☐	☐	*Perpetrator pattern*
Fathers invisible	☐	☐	☐	☐	☐	*High standards for fathers*
Child v. adult survivor	☐	☐	☐	☐	☐	*Child safety and wellbeing tied to adult survivor*

Have a look at how you rated your practice at the end of the 3 days of S&T training. Regardless of whether it is similar or different, can you now re-plot where you think you were in your practice before you started the STACY project?

My practice at the beginning of the STACY project						
Weak nexus	1 Domestic violence destructive	2 Domestic violence neglectful	3 Domestic violence pre-competent	4 Domestic violence competent	5 Domestic violence proficient	Strong nexus
About the adults	☐	☐	☐	☐	☐	*Integrated with children/other CP issues*
"Failure to protect"	☐	☐	☐	☐	☐	*Perpetrator pattern*
Fathers invisible	☐	☐	☐	☐	☐	*High standards for fathers*
Child v. adult survivor	☐	☐	☐	☐	☐	*Child safety and wellbeing tied to adult survivor*

APPENDIX B:

STACY questionnaire qualitative items

The following questions appeared in the *STACY project* online questionnaire conducted with CoP and secondary participants following the CoP phase in 2019. These questions were relevant to the research questions in the current STACY for Children project, however the majority of the STACY questionnaire items were not and are therefore not included in this report.

A secondary analysis, with a child focus, was conducted on the responses to these items as part of the STACY for Children project.

Q24. What do you think your agency, team or partnership is doing best in working with families where there are children and parental issues of mental health and substance use in the context of DFV?

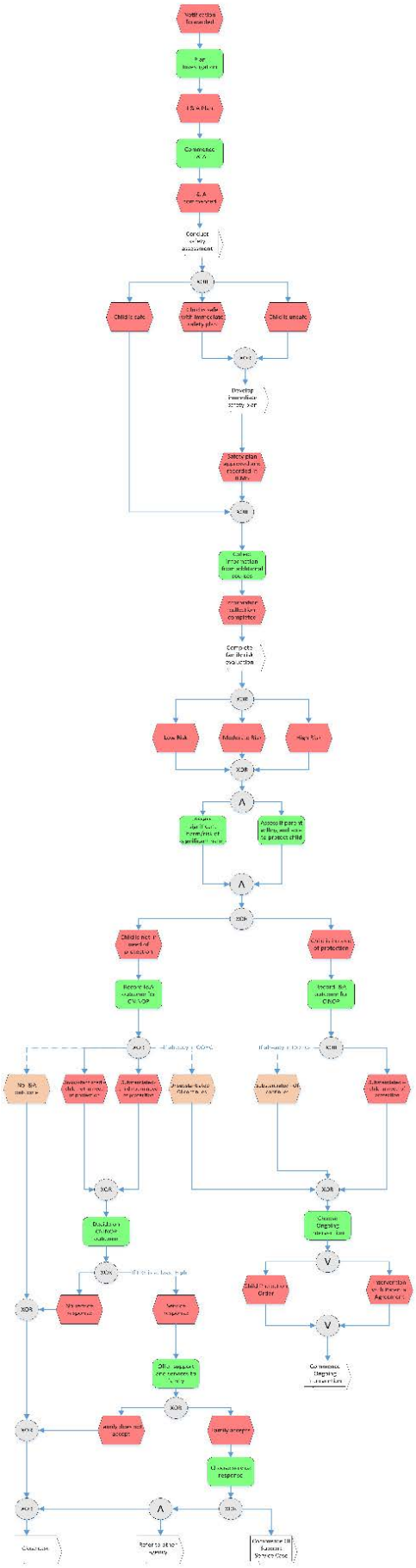
Q25. Regardless of who your clients are, how can practice become more child-focused when working with the intersecting complexities of parental mental health and substance use in the context of DFV?

Q26. When working with children and families living with DFV and parental issues of mental health and substance use, in which area does your agency require the greatest improvement?

APPENDIX C:

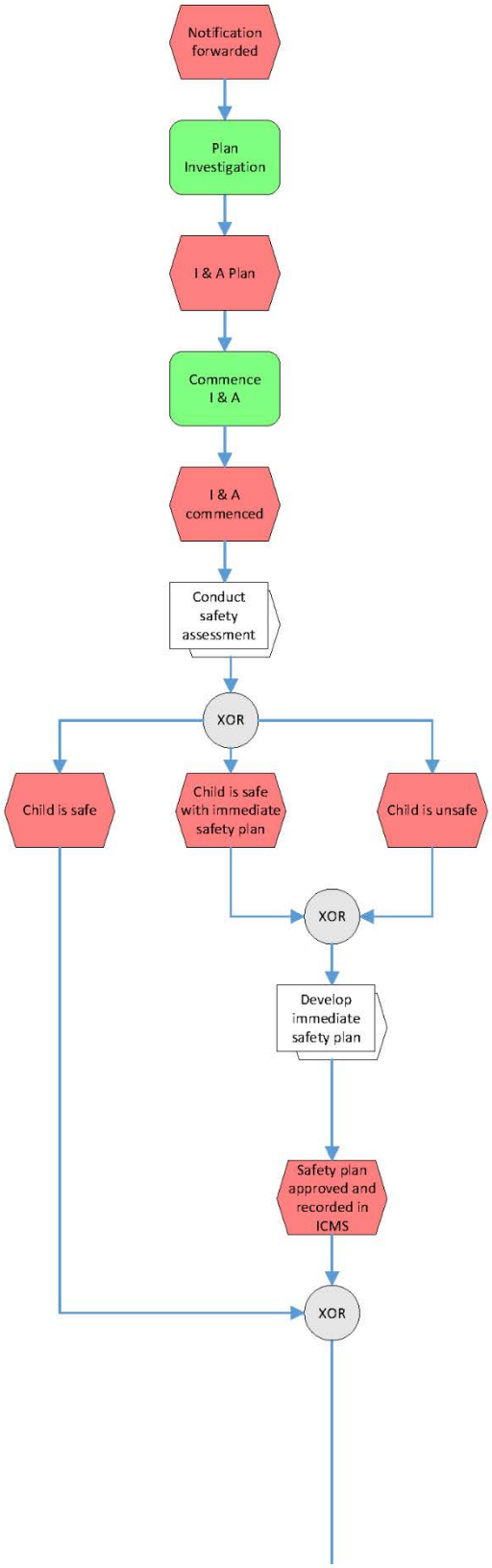
Queensland Child Protection process model from notification to ongoing intervention

Model of child protection process from notification to ongoing intervention

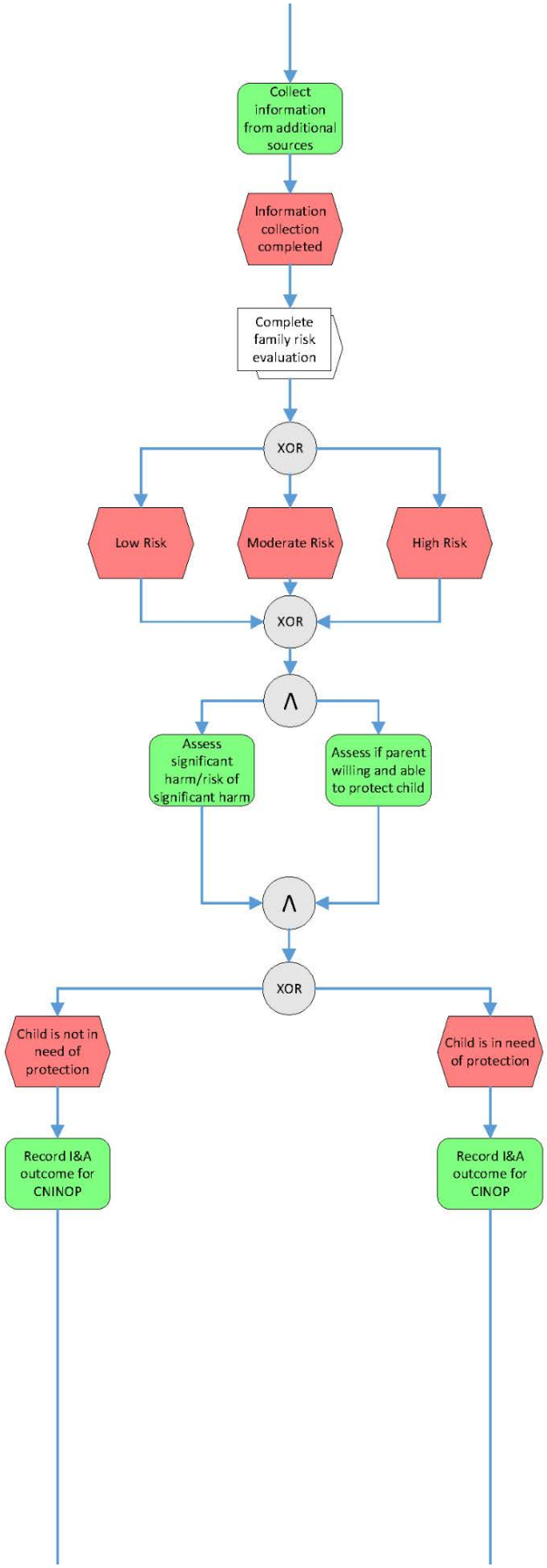


Note: Detailed illustration of each stage of the process is provided in the following three figures.

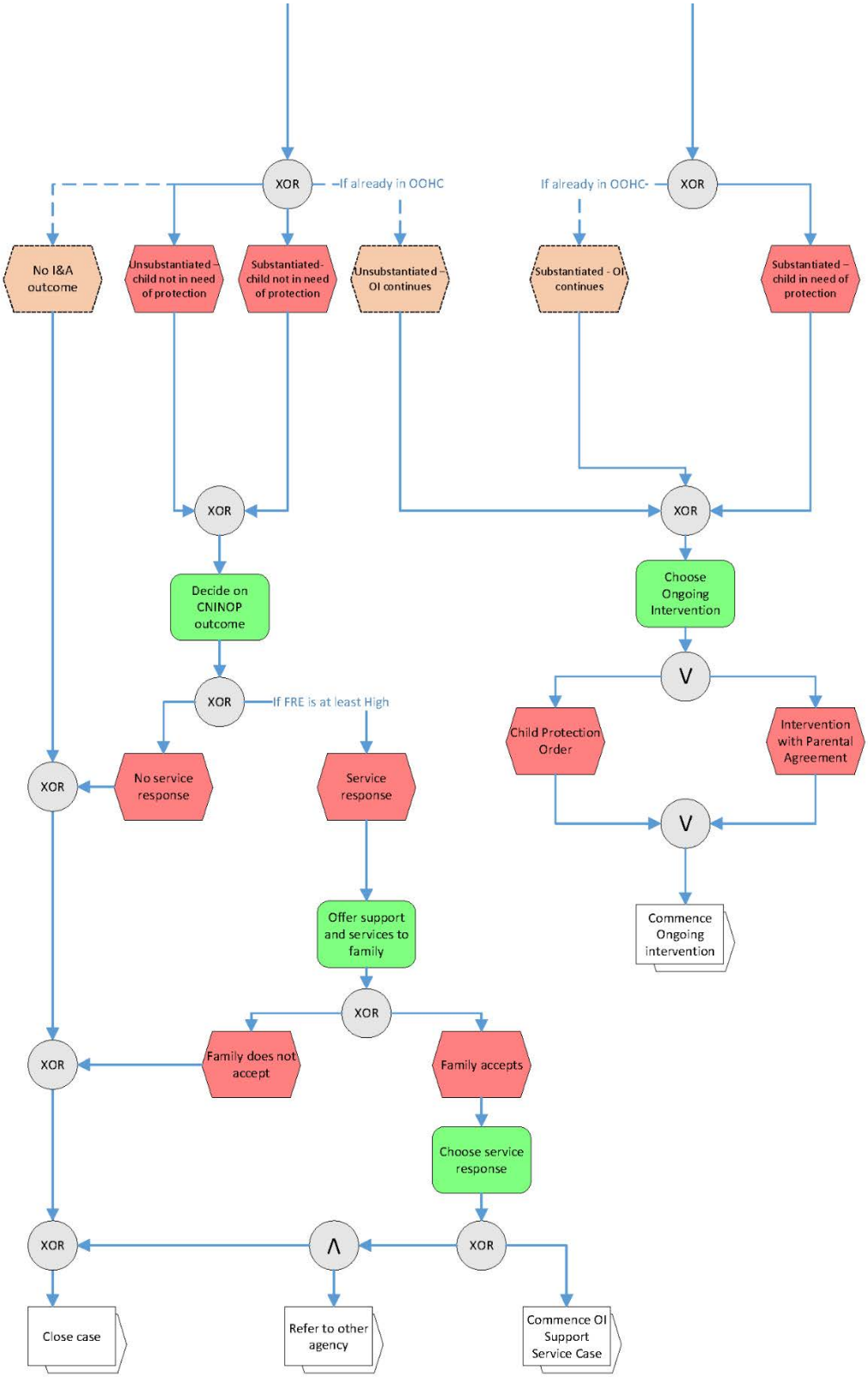
Process model from notification to approved safety plan



Process model from approved safety plan to assessment of need of protection



Process model from I&A outcome to commencement of ongoing intervention



APPENDIX D:

Data quality assurance process

10.1.1 Data transfer and storage

The Queensland Department of Child Safety, Youth and Women (QDCSYW) provided the University of Melbourne with de-identified, unit-record administrative data from their Integrated Client Management System (ICMS). These de-identified, unit-record administrative data are collected as part of case management and include:

- service history
- court order proceedings
- demographic information
- case plan information
- out-of-home care placement information
- types of maltreatment/neglect
- case durations.

These files contained records for all children who were recorded in ICMS between 1 April 2013 and 31 March 2019 within Site C and comparison sites. The extracted administrative data were primarily provided as individual annual reporting files, each produced for an individual reference year running from 1 April through to 31 March, the exception being the structured decision making (SDM) data. The SDM data were provided as a single file containing all risks identified in family risk evaluations (FREs) for assessments across fiscal years 2012–13 to 2018–19, spanning the period 1 July 2012–30 June 2019. The six raw data files provided for each of the "IA—Intakes", "OI—Notified and Substantiated" and "ORDERS—Anytime" types of files spanned the reference years between 1 April 2013 and 31 March 2019.

The "IA—Intakes" data files contained details of one intake per record and included all intakes/notifications where the recorded date of the intake occurred within that reference year.

The "ORDERS—Anytime" data files contained details of one order per record and included all child protection orders (CPOs) and court assessment orders that started on a date within the reference year or were still active during the reference year.

The "OI—Notified and Substantiated" data files were annual summary files of the ongoing intervention activity for a given reference year and contained one reference year for a child per record. The file only included records for those children who had some ongoing intervention during the year with flags indicating whether the activity involved intervention with parental agreement (IPA) and/or a CPO.

The "SDM All Years" data file contained details of one risk type per record for all of the risk types identified during an FRE during the assessment phase of a notification conducted during the 2013–2019 fiscal periods. The assessed level of risk was recorded against each identified risk type as well as an overall final risk score calculated for the FRE across all the risk types recorded for the assessment.

10.1.2 Data management and quality assurance

10.1.2.1 Quality assurance checks

On receipt of the raw data files from the Queensland Government it was confirmed that all the expected files had been provided. We then imported the files into our database.

In order to readily analyse data across the six years, each group of reference year files was combined into one consolidated data file. As a result, four longitudinal data files were created for building the analysis data sets. See table overleaf.

Relationship consolidated to raw data files

Data files (consolidated)	Total records (consolidated)	Raw data files
S&T-IA	24,571	IA–Intakes 31MAR2014
		IA–Intakes 31MAR2015
		IA–Intakes 31MAR2016
		IA–Intakes 31MAR2017
		IA–Intakes 31MAR2018
		IA–Intakes 31MAR2019
S&T-OI	12,698	OI–Notified and Substantiated 31MAR2014
		OI–Notified and Substantiated 31MAR2015
		OI–Notified and Substantiated 31MAR2016
		OI–Notified and Substantiated 31MAR2017
		OI–Notified and Substantiated 31MAR2018
		OI–Notified and Substantiated 31MAR2019
S&T-Orders	21,401	ORDERS–Anytime 31MAR2014
		ORDERS–Anytime 31MAR2015
		ORDERS–Anytime 31MAR2016
		ORDERS–Anytime 31MAR2017
		ORDERS–Anytime 31MAR2018
		ORDERS–Anytime 31MAR2019
S&T-SDM	46,675	SDM All Years

Initial checks confirmed that the data supplied in the extracts covered the data range required for the analysis, i.e. records for intakes from 1 April 2013–31 March 2019. Checks were then run to ensure that all of the requested variables had been provided in each of the data files and that those variables were populated with the expected values. It was specifically checked that mandatory variables including unique identifiers and date and time stamps in each file were populated with non-missing values.

The degree of "missing" values was also assessed in each of the categorical variables, where it was either blank or had a value of "Not stated", "Unknown", or "Not provided", and a value would be expected to have been recorded. Overall the data quality was judged to be very good with minimal data variables values missing (see following table).

Missing value statistics in provided data files

Data files (consolidated)	Variable name	% missing	Missing value/s
S&T-IA	Child's gender	2.2	"Not yet recorded"
	Aboriginal and Torres Strait Islander status	8.7	2.5% "Unknown" & 6.2% "Not specified"
	Child date of birth	0.2	"1/01/1900"
	Assessment approval date	10.5	"1/01/1900"
	Assessment start date	9.2	"1/01/1900"
	Substantiation outcome	14	"Not yet finalised" or "No I&A outcome"
	Planned intervention type	10.6	Blank
S&T-OI	Child's gender	0.4	"Unknown"
	Aboriginal and Torres Strait Islander status	1.4	0.6% "Unknown" & 0.8% "Not specified"
S&T-Orders	Order continuation end date	93	"1/01/1900"—most orders not continued
S&T-SDM	IA event ID		762 IA_event_IDs did not have a matching Assess_event_ID in the S&T-IA data file. Note: most of these were for FREs recorded for the fiscal year 2012–13 and would relate to intakes prior to the earliest reference year of 1/4/2012 to 31/3/2013 of our analysis

The missing dates for commencement and approval of assessment process were primarily an artefact of the non-observation of assessment outcomes for intakes later in the reference year (1 April to 31 March) due to the annual data extraction on 31 May. For assessments where the commencement date for the assessment was missing, the intake approved date was used as a proxy. For assessments where the approval date was missing, the cut-off date of 31 May of the reference year was used as a proxy for the analysis. This cut-off effect is also reflected in the percentage of missing substantiated outcome and planned intervention variables.

Once the completeness of the data was assured, the integrity of the data provided was assessed. It was checked whether any identifier used to link one data record to another related data record actually existed in the other table thus ensuring that the referential integrity between related data records was reliable and could be used to link related data items together for the analysis. For example, child identifiers in one data file are found in a master child data file listing all children in the database.

As these master datasets were not available for the analysis, the integrity assessment instead focused on the reliability of linking identifiers across the data files

provided. These identifiers included *Child_ICMS_ID, Intake_event_ID, Assess_event_ID, IA_Event_ID*, and *FRE_Form_Instance_ID* which are essential in linking related data records together in order to build a longitudinal dataset for analysis.

The *Child_ICMS_ID* was used as the mechanism for linking intake/notifications, ongoing interventions and orders data related to a child together across the data files and across reference years 2013–2019 to build a longitudinal dataset of all their child protection involvement over that period. The *FRE_Form_Instance_ID* was used to link SDM risk type records to the same FRE assessment activity. Some of the event identifiers, such as the *Intake_event_ID* and *Assess_event_ID*, were also used as a grouping mechanism for co-reported children.

10.1.2.2 Consolidated data files

10.1.2.2.1 S&T-IA

This data file contains all notifications where intake started during the period 1 April 2013–31 March 2019 and which then proceeded to the investigation and assessment phase. Each intake/notification is represented by a single record in the dataset. The different intakes for the same child are uniquely identified by their *Intake_event_ID*. Multiple children who are reported together will share the same *Intake_event_ID* so it is the combination of *Child_ICMS_ID* (unique identifier for a child) and *Intake_event_ID* that uniquely identifies each record in the dataset.

10.1.2.2.2 S&T-OI

This data file contains records for all children who had ongoing intervention (IPA and/or CPO) at any time in reference years during the period 1 April 2013–31 March 2019. Each reference year that a child had an ongoing intervention is represented by a single record in the dataset. Only reference years when the child did have some type of ongoing intervention will have a record in the file. Only the type of ongoing intervention in a reference year is indicated by IPA and CPO flags with no other intake/assessment specific details. As there may be multiple reference years with ongoing interventions for a child, there can be more than one record in the dataset linked to the same child via the *Child_ICMS_ID* identifier. The different records for the same child are uniquely identified by their *Ref_start_dates* but individual IPA or CPO events within or across a year for the same child may not be uniquely identified.

10.1.2.2.3 S&T-Orders

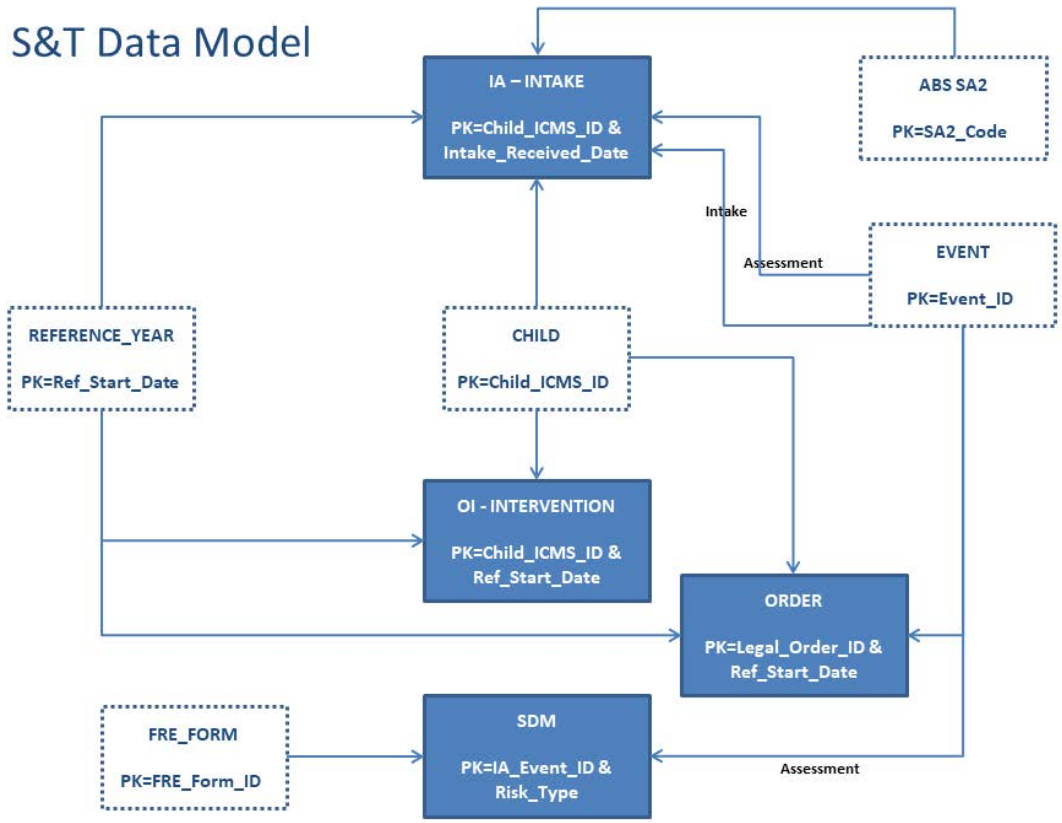
This data file contains all court orders active during the period 1 April 2013–31 March 2019 and removes duplication of orders which are open across multiple reference years (1 April–31 March). Each order is represented by a single record in the dataset. When there are multiple records in the consolidated orders data file for the same order but in different reference years, the data from the most recent record is used so that the most up-to-date data are reflected in the dataset. As there may be one or more orders issued for a child, there may be more than one order record in the dataset linked to the same child via the *Child_ICMS_ID* identifier. The different orders for the same child are uniquely identified by their *Legal_order_ID*.

10.1.2.2.4 S&T-SDM

This data file contains all SDM risk types identified during assessment phase of an intake/notification and where the FRE was conducted during the period 1 July 2012–30 June 2019 (fiscal years). Each unique risk type identified is represented by a single record in the dataset. The different risk types identified for the same assessment event are uniquely identified by their *IA_Event_ID* and link to the assessment event identifier for an intake/notification. The different risk types identified on the same FRE form are uniquely identified by their *FRE_Form_Instance_ID*. Co-reported children from the same family who are assessed together will share the same *IA_event_ID* and *FRE_Form_Instance_ID*.

The data model for this project is presented in the following figure and shows the relationships of individual data entities to each other as well as the identification keys used to link individual entities.

S&T data model for the analysis



10.1.2.3 Data limitations in provided reporting data files

As mentioned in the main body of the report, the reliance on reporting data posed several challenges to the generation of analysis datasets and the analysis itself. The following limitations were observed in the provided data.

10.1.2.3.1 Unobserved outcomes of I&A phase

Non-observation of assessment outcomes information occurred for some intake assessments on 31 May each year due to annual (reference year) raw data extracts being provided for the analysis. This caused significant "blind spots" in the intake/notifications dataset as, for each of the six years of data provided, assessments that were conducted towards the end of the reference year (1 April–31 March) would not necessarily have assessment outcomes information such as approval date, substantiated outcome and planned intervention recorded (see Appendix E).

10.1.2.3.2 Different reporting frequencies

Only annual summary files of ongoing interventions for children were provided, without any start and end dates for IPA and CPO involvement—just flags indicating that there had been an ongoing intervention at some point in time during the year. The dates for CPO involvement were available using the orders file but there were no alternative means to identify unique periods when IPA involvement started and ended and thus which intake/notification it related to. Hence, the research team had to rely on the planned intervention recorded at the outcome of the assessment process which may not reflect what happened for the child (see Appendix G).

10.1.2.3.3 Different reference periods

Inconsistencies between the annual reporting period for intakes/notifications data (1 April–31 March for each reference year) and SDM data (1 July–30 June for each fiscal year). This resulted in mismatched data extract date ranges with SDM data extracted for the period 1 July 2012–30 June 2019, while for the other files, data were extracted for period 1 April 2013–31 March 2019.

10.1.2.3.4 Incompatible identification keys between datasets

Not all case management events were included in the data files provided, specifically the ongoing intervention

event and court/order events. An *Event_ID* identifier was provided on the orders file, but it did not link to any of the event identifiers in the other datasets.

10.1.3 Processes to address conflicting information

For children where multiple notifications were recorded, several variables had conflicting information recorded on the child. These variables were the date of birth, age at intake, Aboriginal and/or Torres Strait Islander status, and gender.

For each of these variables an algorithm was developed to address the data issues. These values were used as an approximation to the real value for each child. For date of birth and children's recorded gender, the mode was used. In other words, the most often stated value was used for each child. If the mode was not identified (e.g. when multiple values had equal frequencies) the latest recorded value was used. Age at intake was subsequently calculated based on the adjusted date of birth.

With reference to a child's Aboriginal and/or Torres Strait Islander status, an indicator variable was generated that took the value of 1 if a child was identified as having an Aboriginal and/or Torres Strait Islander background in any of the recorded notifications.

Finally, one notification was deleted from the data as the subject child had two contemporaneous intake events recorded which resulted in the same *Assessment event ID*. Hence the notification with earlier intake date was chosen as all other recorded information was identical for the two intake events.

APPENDIX E:

Missing values and causal inference

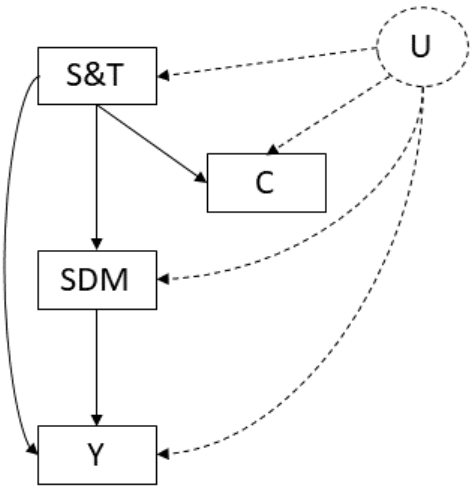
As mentioned throughout the main body of this report, one major challenge for the quantitative analyses was the reliance on data prepared for reporting of process outputs rather than a longitudinal dataset dedicated for statistical and causal analysis. The focus of datasets on periodical reporting resulted in missing values of outcomes and other variables in the intake and assessment (I&A) data and the standard decision making (SDM) items for 10.6 percent and 11.5 percent of all notifications respectively. Process output reporting is usually conducted based on complete cases– that is, incomplete notifications are ignored. For statistical analyses and especially for causal inference studies such as evaluations, this approach poses substantial challenges or can even result in the impossibility of identifying treatment effects at all.

This appendix intends to shed some light on why incompletely observed client pathways may prohibit the estimation of the effects of Safe & Together (S&T) in Site C. Subsequently, an exploratory analysis is conducted to shed some light on potential missing value patterns.

However, in the absence of confounding variables at the centre level, the impacts of missing values on the estimated associations presented in this report remain uncertain and causal inference regarding the effects of S&T in Site C would rely heavily on implausible assumptions. For a more comprehensive discussion of missing values, selection bias and causal inference the interested reader is referred to the relevant literature (Hernán & Robins, 2020; Pearl, 2009).

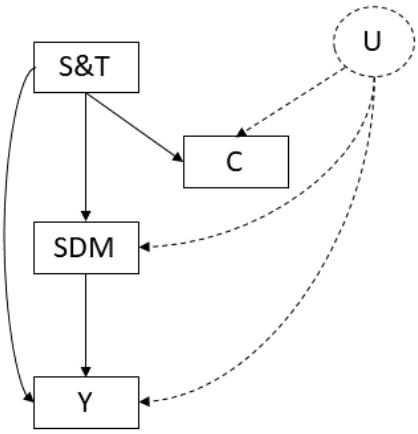
The following figure illustrates a simplified model of the problem of missing values and complete case analysis. In the example, it is assumed that S&T has a direct effect on the assumed outcome Y (e.g. planned child protection order [CPO] or intervention with parental agreement [IPA]) at the end of the I&A process. The variable C indicates "completeness" of the notification record in the Integrated Client Management System (ICMS). In the example, it is assumed for now that the introduction of S&T has contributed to the completion of data records in ICMS and decreases the likelihood of missing outcomes in Site C.

Simplified directed acyclic graph of selection bias in the S&T analysis data



Note: Variables in squares are assumed to be observed. Variables in dashed circles are unobserved. Arrows represent causal pathways between variables. Y represents a binary outcome variable (e.g. planned CPO or IPA). For simplicity, only one risk factor item is assumed to be measured (SDM). The variable C represents a binary variable indicating whether a notification pathway is completely observed (C = 1) or not (C = 0). Unobserved variables are summarised in U and represent centre-level confounding factors (e.g. CSO caseload, service collaborative networks).

Possible selection bias in the S&T analysis data when S&T and U are independent



Note: Variables in squares are assumed to be observed. Variables in dashed circles are unobserved. Arrows represent causal pathways between variables. Y represents a binary outcome variable (e.g. planned CPO or IPA). For simplicity, only one risk factor item is assumed to be measured (SDM). The variable C represents a binary variable indicating whether a notification pathway is completely observed (C=1) or not (C=0). Unobserved variables are summarised in U and represent confounding factors (e.g. CSO caseload, service collaborative networks).

Hence, the variable S&T has an effect on the completeness of outcome records as well as the recording of SDM items (e.g. DFV indicators). This will in turn may have an impact on the family risk evaluation (FRE) scores. Overall, S&T is therefore expected to have both direct and indirect effects on the outcome of the investigation and assessment. If no unobserved factors were to be present in the figure on p. 113, the analysis of S&T would be straightforward from an effect identification perspective. Unfortunately, this assumption is unlikely to hold as unobserved factors are likely to confound the estimated effects of S&T on Y. For example, unobserved factors at the Child Safety Service Centre (CSSC) level (e.g. Child Safety Officer [CSO] caseloads, well-coordinated integrated service provision) may have impacted the selection of Site C as an S&T implementation site. For example, assume that U represents CSO caseload. Factors related to caseload are likely to be related to the implementation of S&T in Site C. On the other hand, higher caseloads may also increase the likelihood of missing outcomes in the data due to extended I&A durations (i.e. the I&A process is more likely not to be completed prior to 31 May of the relevant year). Finally, higher caseloads may directly impact the planned intervention and the FRE completion. Consequently, the effect of S&T on the outcome Y cannot be identified. Moreover, even if U is independent of the S&T variable, as is shown in the figure above, conditioning on complete cases only will lead to biased estimates of causal effects.

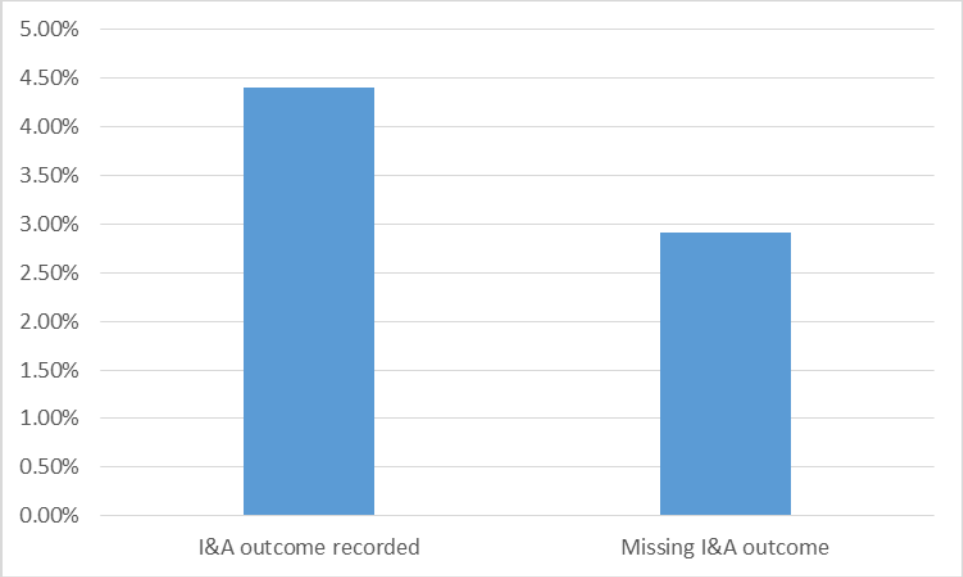
The graph in the figure above also emphasises that in the presence of systematic missing values in the data, complete case analysis may lead to selection bias, even if the confounding factors are independent of S&T. By conditioning on C, the analyst opens a backdoor pathway from S&T to the outcome variables. This prevents the identification of causal interpretation of observed effects. An example would be in the case of family characteristics impacting the likelihood that the I&A process is not completely observed in the dataset. In the figure above, such a relationship between U, C, Y, and S&T would render the treatment effect of the availability of S&T unidentifiable.

11.1.1 Exploration of missing value patterns in the data

As mentioned in the previous sections, data extraction processes for periodical reporting resulted in missing values for several variables, including the substantiation outcomes and planned ongoing interventions as well as the FRE data items.

These missing values may prohibit a generalisation of findings from this study to the population of notifications recorded in included CSSCs during the observation periods. In this appendix, missing value patterns are assessed to investigate whether notifications with missing values differed across several available characteristics from completely observed notifications. However, while the findings in this section are informative, it must be noted that the data available for comparison of these two

Distribution of OOHC outcome by availability of I&A outcomes



Note: Bars show shares of OOHC placements in percent of notifications with either recorded or missing I&A outcomes. Included are all notifications with intake date after 31 March 2014 and imputed I&A approval date prior to 1 December 2018.

groups were very limited. This is because most of the information included in the data extracts was collected during the I&A phase, which was not represented in the data for notifications with missing outcomes.

11.1.1.1 Notification characteristics when the outcome is not yet finalised

The I&A guidelines of the Queensland Department of Child Safety, Youth and Women stated that an investigation and assessment must be finalised (including approval) within 100 days from date of the notification (Queensland. Department of Child Safety, Youth and Women, 2017). Therefore, for the purpose of the analyses conducted in this section, missing assessment approval dates were imputed based on the following algorithm:

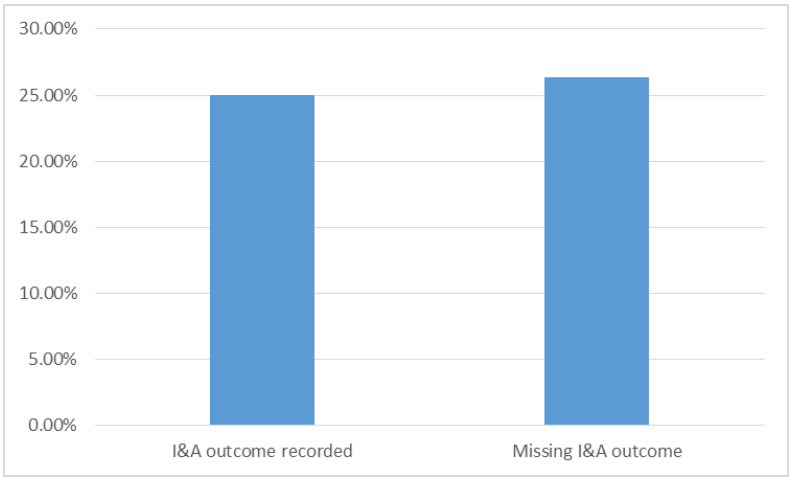
- adding 60 days to the assessment start date if the assessment start date was recorded in the data, or
- adding 100 days to the intake start date if the assessment start date was missing.

A measure of out-of-home care (OOHC) placement was generated based on an indicator taking the value of 1 if a CPO was issued within 180 days from the imputed assessment approval date that placed the child in OOHC. The indicator switched to 1 only if no further intake was observed for the child between the imputed assessment approval and the closest CPO date placing the child in OOHC.

The figures above and overleaf depict population characteristics and differences between notifications with missing I&A outcome and those that were completely recorded in the data extract. For the investigation of OOHC placements, the coverage period was reduced to include notifications that were recorded after 31 March 2014 and had an imputed assessment approval date prior to 1 December 2018. This was done to ensure that notifications would have a six-month follow-up period. For other analyses, all notifications were included that commenced after 31 March 2014.

A statistically significant difference was observed ($p < 0.01$) regarding the likelihood of missing notifications receiving an OOHC placement within six months following the imputed assessment end date compared to completely observed notifications. Namely, notifications with a missing I&A outcome were less likely to have an OOHC placement recorded within six months from imputed assessment end date compared to completely observed notifications. Further sensitivity analysis was also conducted using information on court orders and notification dates and these results confirmed the robustness of the approach outlined here. The figure above presents the distribution of OOHC outcome between notifications with missing and non-missing outcomes.

Distribution of Aboriginal and Torres Strait Islander children by availability of I&A outcomes



Note: Bars show shares of notifications that included Aboriginal and Torres Strait Islander children expressed in percent of notifications with either recorded or missing I&A outcomes. Included are all notifications with intake date after 31 March 2014.

Distribution of female clients by availability of I&A outcomes

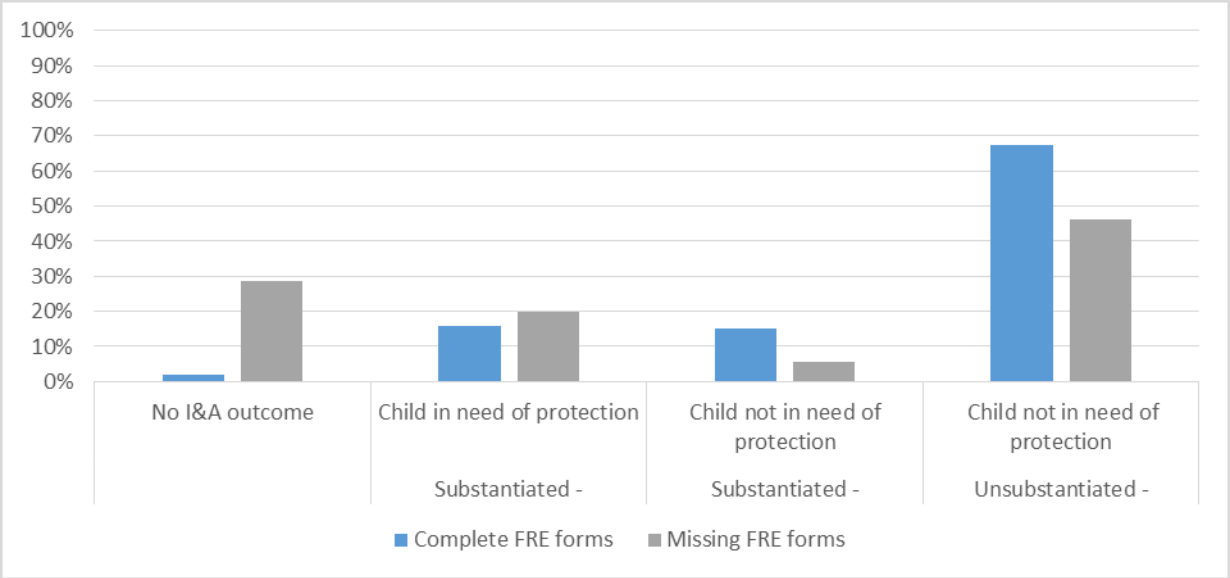
Note: Bars show shares of notifications that included female clients expressed in percent of notifications with either recorded or missing I&A outcomes. Included are all notifications with intake date after 31 March 2014.

In addition to issued CPOs, some child characteristics were recorded as part of the intake phase, irrespective of whether a notification had missing outcomes or not. Due to limitations in the data for notifications recorded prior to April 2014, the analysis is restricted to notifications recorded after 31 March 2014.

The figure at the top of the page represents the distribution of Aboriginal and Torres Strait Islander and non-Indigenous children. No significant differences were observed ($p = .135$) between the two groups, suggesting that children's Aboriginal and/or Torres Strait Islander background was not associated with a higher probability of incomplete I&A records.

Missing outcome differences were also examined across gender, represented by a binary variable taking a value of 1 if the child was recorded as being female and 0 otherwise. The second figure depicts the gender distribution of missing outcomes for notifications. Overall, the differences in gender distributions were not statistically significant with regard to missing outcomes. However, it is worth noting that the gender composition between notifications with missing outcomes and their completely observed counterparts varied substantially over time and CSSCs.

Frequency of assessment outcome between complete and incomplete FRE forms



Notes: Bars show distribution of each I&A outcome category in percent of all notifications recorded between 1 April 2013–31 March 2019.

Overall, there were also large differences in the frequency of missing outcomes for notifications over time and across CSSCs. In the case of Site C, a decreasing trend in the number of notifications with missing outcomes was observed from 2016 onwards. If this pattern is at least partially due to the introduction of S&T then the probability of missing outcomes is itself impacted by the intervention, which would indicate potential selection bias in the data as explained in Appendix E.

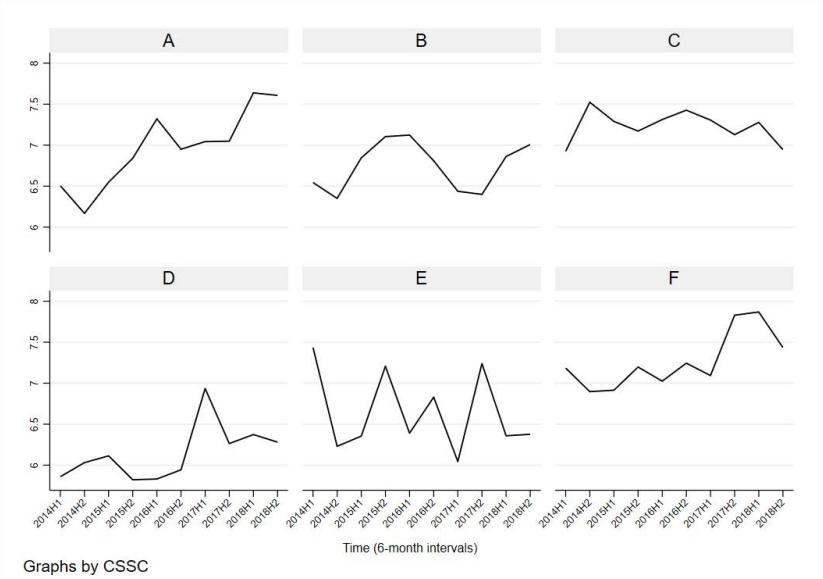
11.1.1.2 Outcome characteristics when the FRE form is missing

For notifications where FRE information was not available in the data extract, an analysis of the recorded I&A outcome category at data extraction was conducted. The results are presented in the figure above. These I&A outcome categories included the category "Not yet finalised" to represent notifications for which no substantiation outcome was available from the data. Distributions of I&A outcome categories differed between notifications with observed and missing FRE information at the 95 percent confidence level ($p < .001$). Compared to notifications with available FRE forms, incomplete forms were more likely not to have been finalised or be within the category "No I&A outcome". Notifications with available FRE forms were more likely to receive a child not in need of protection outcome irrespective of the notification being substantiated or unsubstantiated. Substantiated child in need of protection outcomes were also less likely to have missing FRE forms, although this difference was smaller compared to the child not in need of protection cases.

APPENDIX F:

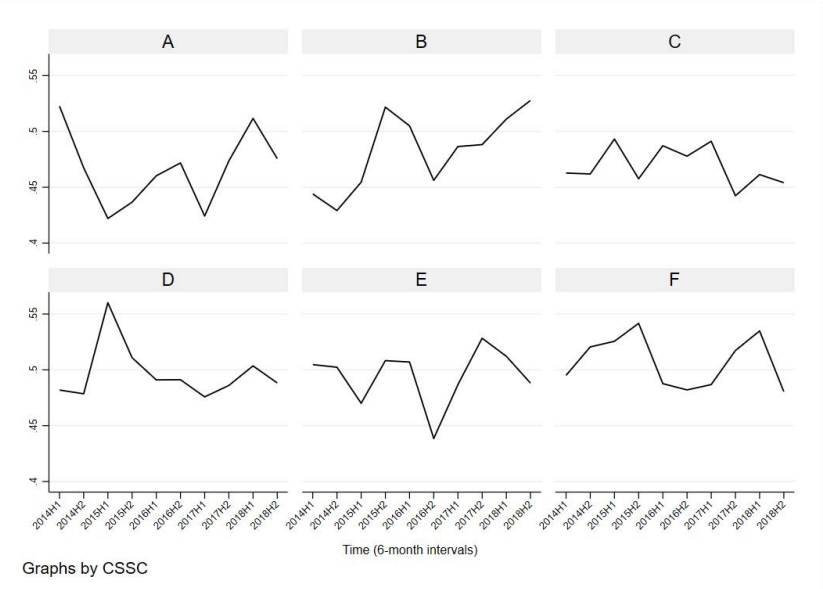
Descriptive statistics by Child Safety Support Centre (CSSC) over time

Average age at intake by CSSC over time, 1 April 2014–31 March 2019



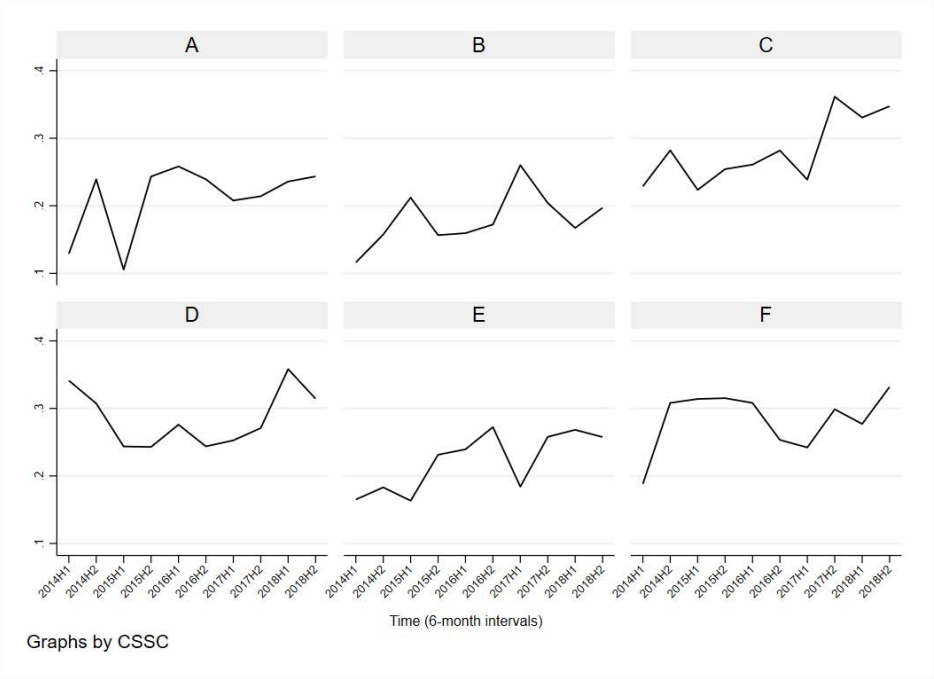
Note: Vertical axis shows proportion of all notifications. Cases without observed outcome included in the denominator. H1 and H2 refer to six-monthly periods from 1 April–30 September and 1 October–31 March respectively. Denominator includes all notifications recorded within particular period.

Proportion of female children in notifications by CSSC over time, 1 April 2014–31 March 2019



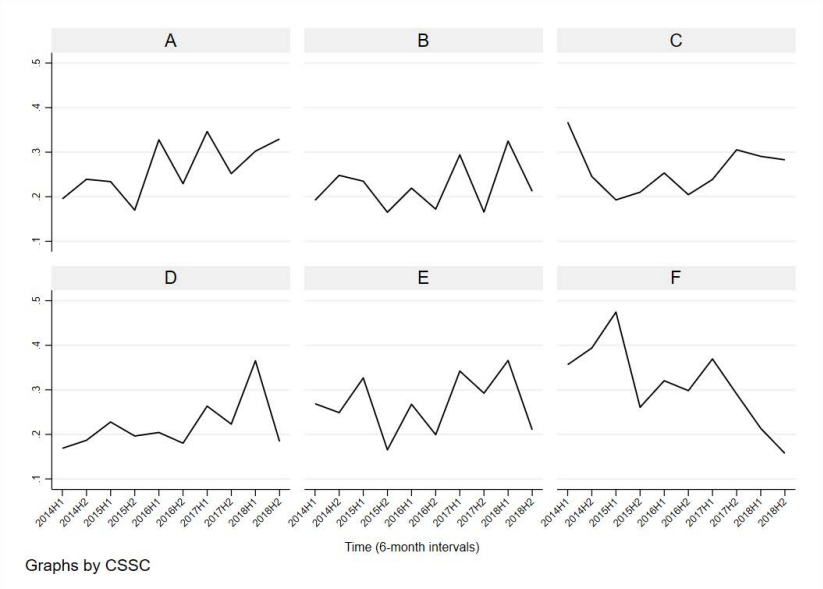
Note: Vertical axis shows proportion of all notifications. Cases without observed outcome included in the denominator. H1 and H2 refer to six-monthly periods from 1 April–30 September and 1 October–31 March respectively. Denominator includes all notifications recorded within particular period.

Proportion of Aboriginal and Torres Strait Islander children by CSSC, 1 April 2014–31 March 2019



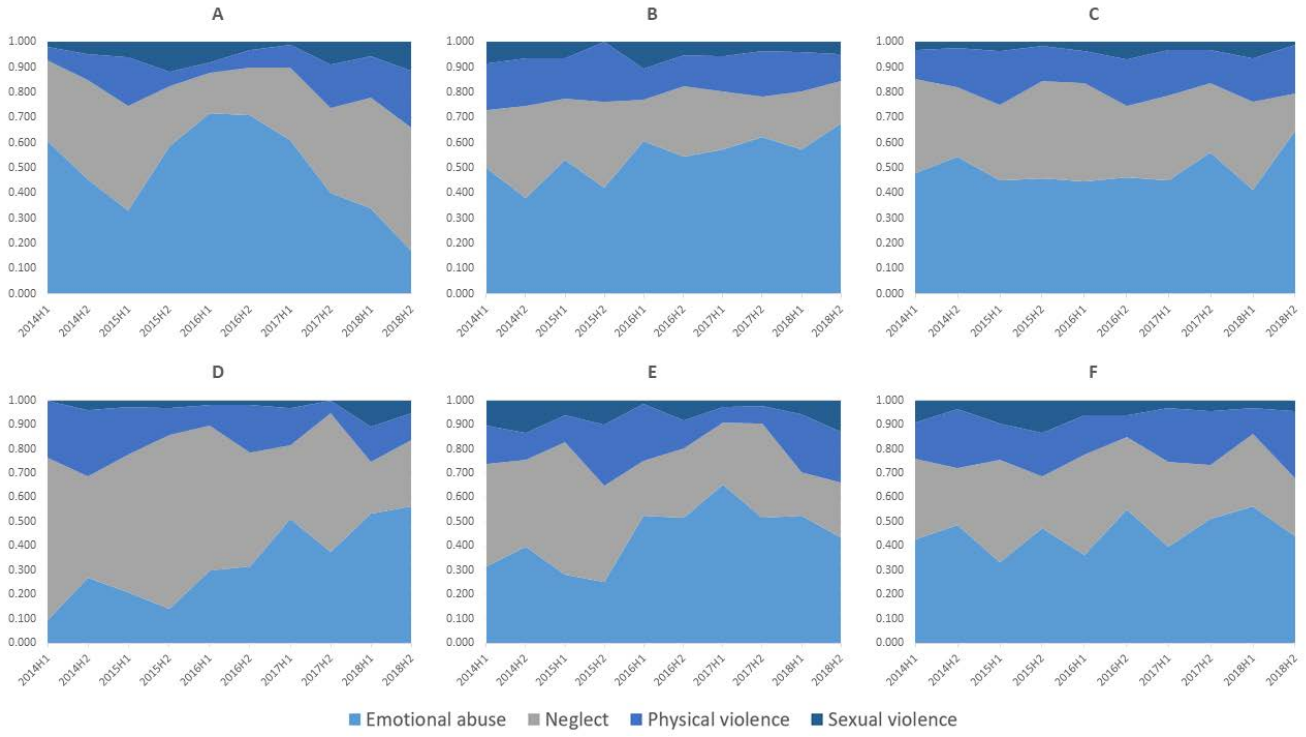
Note: Vertical axis shows proportion of all notifications. Cases without observed outcome included in the denominator. H1 and H2 refer to six-monthly periods from 1 April–30 September and 1 October–31 March . Denominator includes all notifications recorded within particular period.

Substantiated notifications by CSSC, 1 April 2014–31 March 2019



Note: Vertical axis shows proportion of all notifications. Cases without observed outcome included in the denominator. H1 and H2 refer to six-monthly periods from 1 April–30 September and 1 October–31 March . Denominator includes all notifications recorded within particular period.

Type of substantiated abuse, by CSSC and half-year April 2014–March 2019



Note: Only substantiated type of abuse was included. Area plot shows proportions of each type of abuse within respective year. For each year and CSSC, proportions of type of abuse add to 1. Year indicated as the start year of the reference period, i.e. 2014H1 refers to period 1 April 2014–30 September 2014 while 2014H2 refers to period 1 October 2014–31 March 2015. S&T was implemented from 2016H2 onwards.

APPENDIX G:

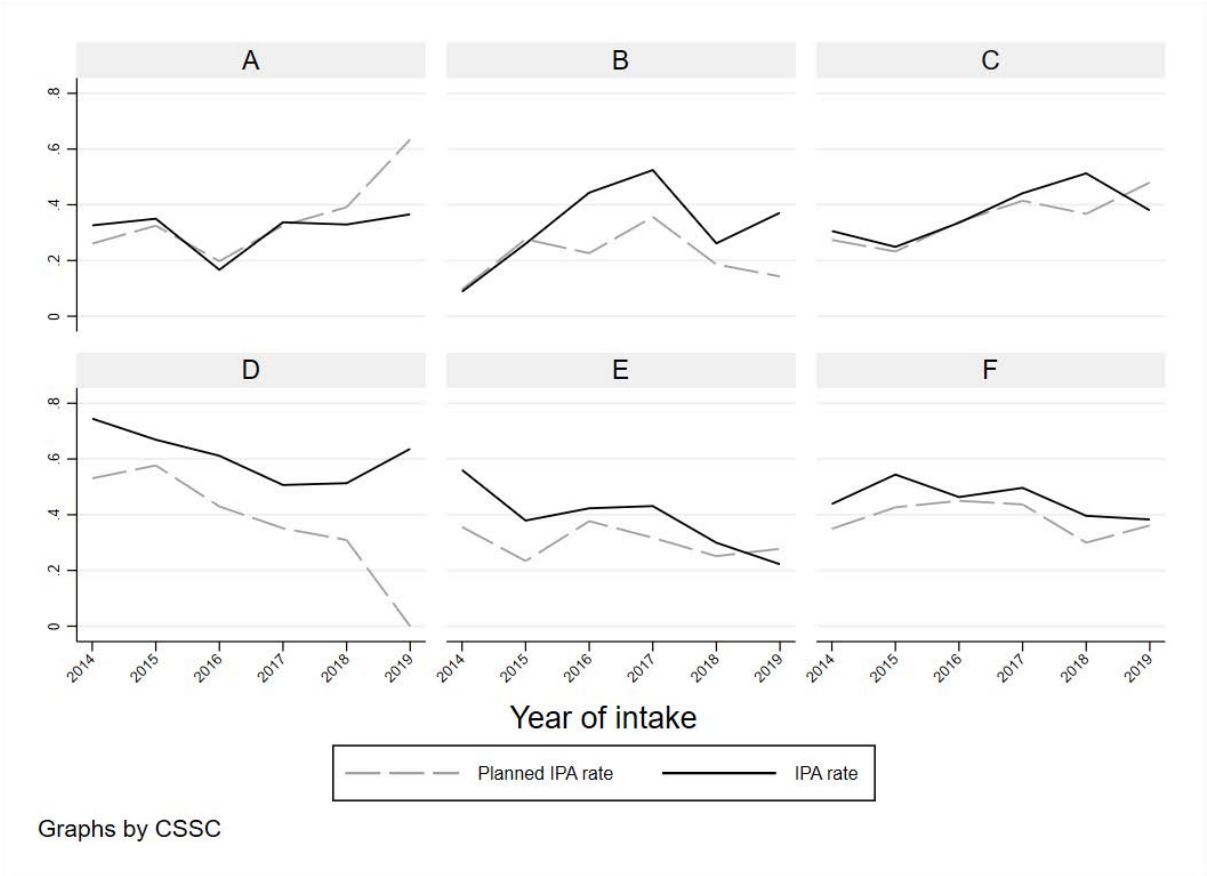
Supplementary information on outcomes measures

Interventions with parental agreement (IPAs)

As outlined in the main body of the report and in earlier appendices, the data files including information on actual IPA placements for children could not be reliably linked to notification and investigation data. As a consequence, a measure of planned IPAs was derived from the intake and assessment (I&A) data file as a proxy for IPA placements.

However, since counting processes for reporting differ between ongoing intervention files and the notification dataset, it was expected that the number of planned IPAs differed from the actual IPAs recorded each year. Furthermore, difference between the two constructs can arise due to the fact that actual IPA placements may have commenced after some time following the approval of the I&A phase due to case planning procedures. The below figure illustrates planned and actual IPAs for each year of intake as proportions of substantiated notifications. It is evident from the graph that there are some divergences between the curves across Child Safety Service Centres (CSSCs).

Planned versus actual IPA placements, by CSSC and year of intake



Note: Figure shows notifications where planned intervention at the end of the I&A phase was IPA vs actual IPA placements in a given reference year. Illustrated are ratios of number of each outcome relative to the number of substantiated cases in the particular reference year in the denominator.

Placements in out-of-home care (OOHC)

While different specifications for an outcome variable to measure placement in OOHC were considered, the described binary variable was chosen based on several considerations. Firstly, for substantiated notifications with children in need of protection and a recorded child protection order (CPO) issue date following the intake and assessment (I&A) approval date, over 87 percent of CPO issue dates were within 180 days of the I&A approval date for that notification. Secondly, while a 12-month follow-up was considered, this approach would have resulted in a substantial decrease of sample size for some analyses. Especially for Site C, more than 97 of CPO issue dates are within 180 days from I&A approval date. Across all CSSCs included in the analysis, coverage rates of the six-month out-of-home care indicator range from approximately 80 percent in Site A to 89 percent in Site E. In order to ensure approximately similar coverage rates between CSSCs, the duration between CPO issue date and the I&A approval would have needed to be increased to two years of follow-up period, dating back to 31 March 2017, resulting in a substantial reduction in sample size.

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