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All-of-family responses to children, mothers and fathers accessing services for domestic and family violence in Victoria, Australia

Safer Families Centre

Policy and Practice Discussion Paper

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Introduction

The Safer Families Centre researches and collaborates to transform the health sector to address DV. We are working for a future where health services can support any member of a family affected by DV through appropriate engagement, programs and referral to services appropriate to individual family needs.

Domestic violence (DV) may involve physical, emotional or sexual violence, as well as a range of controlling behaviours, and results in an atmosphere of control and fear within families, affecting all family members. It affects family functioning, compromises parenting by all caregivers, and is a form of child abuse or neglect. (1)

The universal health system is the most common point of access into the service system by all those involved in DV: children or adults, survivors or perpetrators. (2) While prevention work commonly occurs within universal services, individuals and families may be referred to early intervention, response or recovery and healing services, and back to universal services. There is no linear progression through a range of services, rather a network of universal and specialist services. Strong connections and collaboration are essential for all parts of the system to contribute to supporting any member of a family affected by DV. (3)

Patterns of DV predominantly involve a male perpetrator using violent, abusive and controlling behaviours towards a female victim survivor. Children are also affected by a family member using DV in their home. (4) However, this is not a universal pattern - DV occurs across genders and in all types of families, such as heterosexual, same sex couples and families that include wider kinship networks. The SAFER Family Centre projects which inform this brief focus mostly on the predominant pattern, and this is reflected in this paper.

An all-of-family approach (sometimes referred to as 'whole of family' approach) engages with all family members – caregivers in mothering or fathering roles and children – in families living with DV. It considers each individual's needs and behaviours in the context of family with a particular emphasis on addressing parenting issues. Unlike family therapy approaches, 'all-of-family' engages with family members separately where safety is an issue.

While DV is perpetrated in all parts of society, it may be experienced differently, depending upon gender, sexuality, race, and experiences of disadvantage and trauma. For Aboriginal and Torres Strait Islander families, past and present trauma, impact of colonisation and the legacy of extreme social disadvantage, contribute to higher rates of DV and the further disruption of mother-child bonds through removal of children into out-of-home care. Migrant and refugee families also face challenges relating to racism, culture and migration status.

This policy and practice brief summarises lessons learnt about all-of-family approaches to DV in the context of the Victorian service system, with a focus on Australian research, and evidence developed through Safer Families Centre of Research Excellence projects (see www.saferfamilies.org.au). The recommendations will be useful to decision makers of programs aimed at parenting in the context of DV.

The problem in Australia - why all-of-family approaches are needed

At the Safer Families Centre, we address the lack of focus on parenting in service responses to promote safety and resilience.

The lives of infants, children and young people are significantly affected by DV

DV affects all family members, and there is growing evidence of the impact on children. (5)

- While one in six Australian women has experienced violence from an intimate partner during her lifetime, half to two-thirds of these women had children in their care at the time of the violence. (6)
- A recent longitudinal study of women, initially recruited at the birth of their first child, reports that more than one in three of these women's children experienced DV by the time they reach 10 years of age. (1) Infants and children exposed to DV are more likely to experience insecure attachment, depression and anxiety, substance use issues, aggression and attention deficit hyperactivity disorder, compared with children not exposed. (1)
- The impact of DV on infants, children and young people is variable. In any sample of children living with DV, one-third or more are doing as well as other children when compared with community samples. (1, 7)

Parenting - DV can compromise mothering and mother-child relationships

- Infants and children need safe, secure parenting relationships in order to develop and thrive. Protective caregivers can emotionally shield children from the effects of traumatic experience. (8)
- Mothers subjected to DV generally have poorer physical and mental health. Living with DV can also impair their experience of motherhood and create difficulties for them in responding to the needs of their children. While some women are able to heal and recover over time, for others these difficulties persist well beyond the experience of violence. (9, 10)
- Fathers who use DV often directly attack the relationship between a mother and her child, through physical attacks, undermining their parenting or manipulating the children. (11)
- Fathers may also continue to make their presence felt beyond separation, either through the legacy of their violence or through actual continuing contact, control and causing ongoing stress, at a time when mothers are caring for traumatised children on their own. (12)
- Aboriginal women may be particularly disadvantaged by lack of access to culturally safe services and fear of child removal. (13)

Strengthening the mother–child relationship is vital for children's protection and recovery, and this involves attending to mothers' well-being as well as the mother-child bond. (14-16)

DV damages fathering and father-child relationships

When a father uses violence and abuse in the home, the father-child relationship is damaged or destroyed, sometimes permanently. (17) In recent research, children of violent fathers have reported their desire for fathers to admit and apologise for the harm they have caused through past behaviour, accept the consequences, and in some cases, demonstrate that their behaviour and attitudes have changed, "stepping up" to parenting. (18)

Evidence-based programs that help perpetrators address their behaviours, and recognise these behaviours as parenting choices, therefore play an important role in a DV service system. (17)

Co-parenting arrangements are sabotaged by DV

Co-parenting includes the way both parents take on caregiving responsibilities, communicate with each other and support each other's parenting.

Fathers who use violence generally show little understanding of the impact on their children of co-parenting conflicts. (19)

Even when parents have separated, continuing father-child contact provides an opportunity for the father to continue abusive behaviour and undermine relationships, perpetuating the damage. (19)

Evidence-based programs that promote co-parenting, and consider both mothering and fathering, build safety and resilience for families.

Service system responses are still developing

Despite efforts in recent years to develop integrated responses to DV at all stages of the service pathway, several barriers exist to providing families seeking effective help.[a]

A service system structured in silos such as specialist DV, physical or mental health, child welfare, substance misuse, housing and justice **is difficult to negotiate for families affected by DV.**

The focus of non-DV services (eg. family support, AOD, MH etc) may lead to DV becoming invisible as a key factor in family functioning. (20)

Integration between universal services and DV specialist services for prevention or early intervention, response or recovery, is poor, with unclear referral pathways. (21)

A narrow service focus on survivors or perpetrators / adults or children, loses an all-of-family perspective on family functioning without effective collaboration

Survivors are not eligible for many DV services unless they have separated from the perpetrator of violence. However, separation may be unsafe, prevented by a survivor's dependence on their partner for residence in Australia or a lack of affordable housing, or undesirable for survivors hoping to keep their family intact.

A lack of focus on parenting and co-parenting in DV and other services may lead to the violence and parenting practices of fathers being overlooked while mothering is closely scrutinised. (20)

Infants and children are often invisible as individuals with their own unique experiences of DV and related support needs, whether or not the service targets children. (8, 17, 22)

'Cultural safety' is often ignored by current service system responses promoting only victim/survivor safety.

Evidence-based programs that promote survivor safety and help perpetrators address their behaviours, recognising them as parenting choices, play an important role in a service system. (17)

[a] An example is a state-wide network of support and safety hubs in Victoria (Orange Door) which bring together a range of support services focussing on DV response.

Key Principles for a system addressing DV through all-of-family approaches

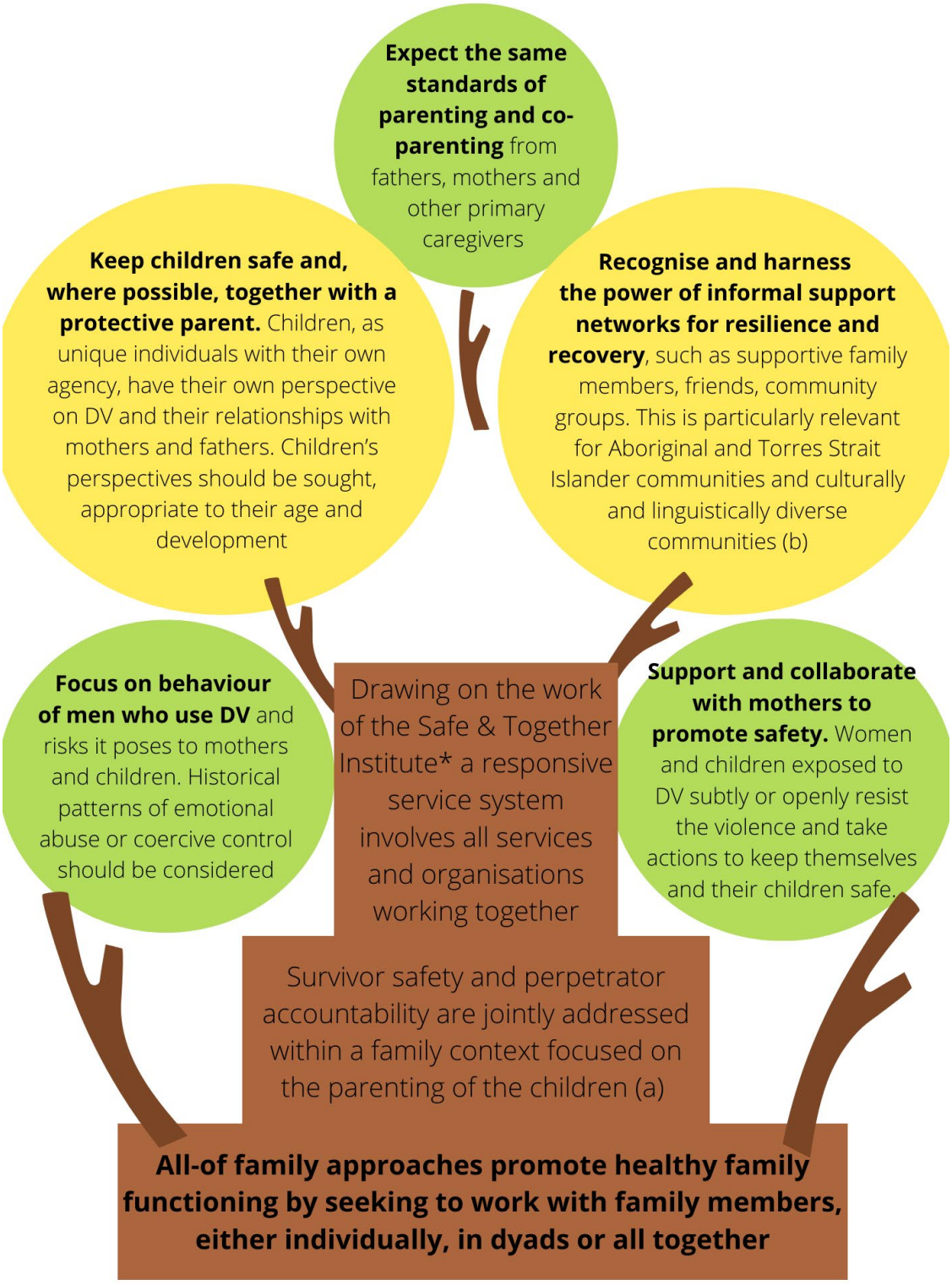

Figure 1 Key Principles for a system addressing DV through all-of-family approaches

*https://safeandtogetherinstitute.com/
(a) Reference 23
(b) Reference 24

What are the components of a service system that supports all-of-family approaches to addressing DV?

In the context of current service reforms, and the emphasis in Australian policy documents on the availability of evidence-based programs, (25-27) the Safer Families Centre is evaluating evidence-based programs that address parenting to assist families living with or recovering from DV. A summary of these programs can be found in the Appendix.

A synthesis of these individual program evaluations shows that program effectiveness involves both quality of content and delivery, and program integration into a wider service system that supports all-of-family approaches to addressing DV. The structure of this system, or authorising environment, is pivotal to service effectiveness, and functions at several different levels. These can be described as a series of relationships:

1. The relationships between family members are important factors affecting individual risk or well-being.
2. The relationship between frontline professionals and the family members they work with.
3. The relationship between organisations and frontline professionals, including management expertise, organisational policy and procedures.
4. The relationship between the service system and the organisations which are part of it, including system level policy and legislation, and organisational collaboration.

Components of an effective service system are illustrated in (figure 2) and discussed below.

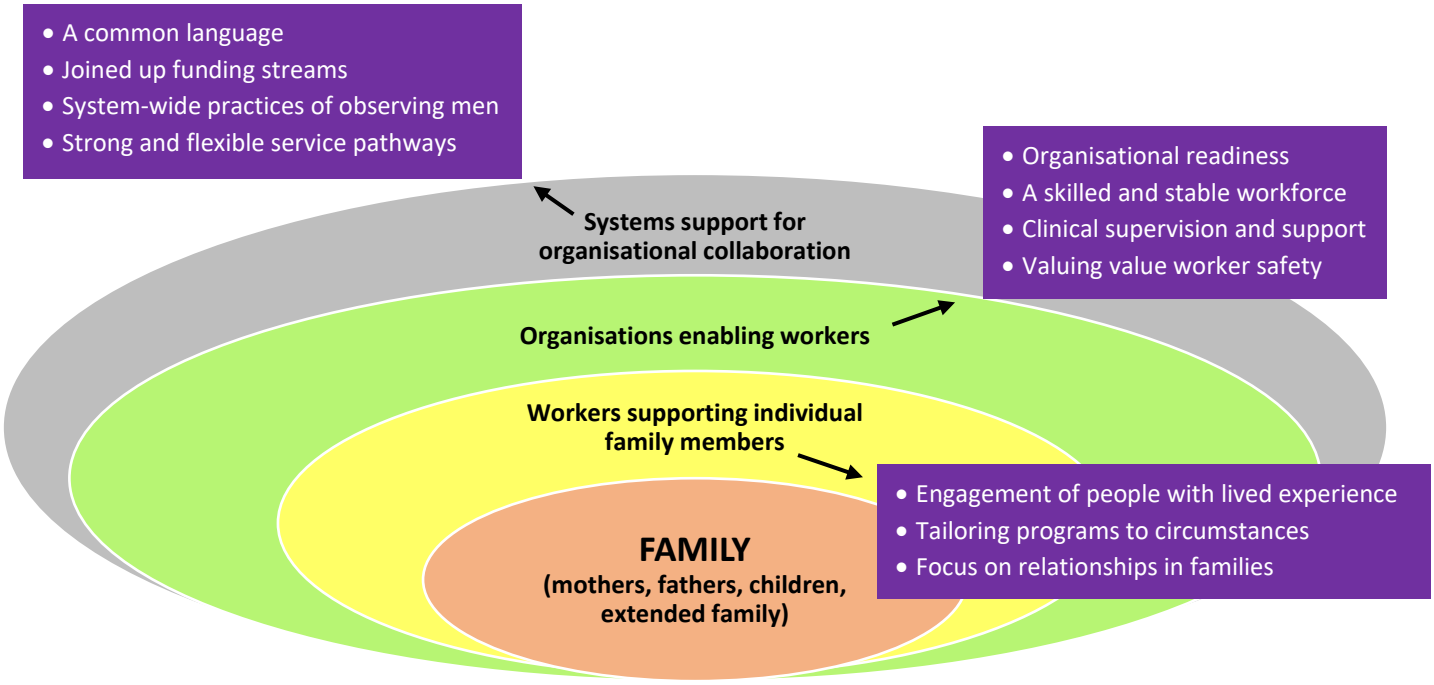

Figure 2. Components of all-of-family approaches and the authorising environment

Frontline professionals supporting family members

Engagement of people with lived experience is central, as many have little trust in services due to past experiences of being judged or not listened to. This may be particularly true for Aboriginal families where both past history and current practice lead to them feeling culturally unsafe in mainstream services.

- Engagement is promoted by clear information, assertive outreach and non-judgmental and reassuring intake staff.
- Frontline professionals require relevant skills and understanding of DV and a range of intersecting issues.
- As most help-seeking and successful engagement follows a crisis, reassuring and timely referral pathways will harness motivation to engage with services at this time. (28) Strong referral pathways to appropriate services maximise the chance of people with lived experience engaging with programs - with personal introductions (warm referrals) from referring professionals and strong information flow from specialist programs through networking to ensure that programs are known well in advance of program commencement. (17)

Tailoring programs to individual and family circumstances promotes effective service delivery to a wider group - through a range of strategies:

- offering services outside business hours,
- individual alternatives to groupwork,
- recognising the needs of children 'in their own right'
- tailoring program materials and approaches to suit differing educational or intellectual abilities and cultural and ethnic backgrounds
- addressing social factors by providing practical support where appropriate (housing insecurity, low income, loss of community and friendships). (29, 30)

A focus on relationships in families, particularly between parent and child, facilitates simultaneous healing and recovery for parents and children, with potential benefits for future generations. (8, 30)

A focus on relationships in community, supports and educates informal support networks will include 'step down' services that provide a path for victim/survivor to mainstream service support.

The relationship between professionals and organisations: supporting effective program provision and service delivery

Programs and professionals who identify and address DV, operate within an organisational culture that affects program delivery and therefore outcomes for family members.
A skilled and stable workforce is required at all points on service pathways. Frontline professionals require knowledge and skills to recognise and respond to DV, conduct screening, risk assessment, safety planning and make appropriate referrals.

- DV aware leadership is fundamental to providing effective services by skilled professionals.
- Ongoing professional development for staff will build expertise within organisations. (31)
- Adequate and sustainable resourcing of programs, manageable caseloads and access for staff to multidisciplinary expertise, will attract and retain skilled professionals.
- Staff retention can also be optimized by organisational planning for an adequate pool of frontline staff, to enable planned leave, maintenance time between intense service provision periods and crisis backup. (30)

Organisational readiness to support all-of-family work: To provide timely and effective interventions, organisational policies, procedures and leadership should enable frontline

professionals to support individuals in their family context and to focus on their safety.

- Organisational readiness requires DV-aware leadership, as well as arrangements for DV informed supervision and training for all staff.
- Management expertise in all-of-family work is essential to encourage collaboration between services at practitioner level.
- Organisational cultures should promote intersectoral assistance to families across the traditional service silos of work with adult victim survivors, work with children and work with perpetrators, and of traditional areas of expertise - health, mental health, alcohol and other drugs, homelessness, etc. (32)

Provision of clinical supervision and support: Work with families living with DV is complex, intense and can lead to workers experiencing vicarious and cumulative trauma.

- Skilled clinical supervision and support, separate from line management, is a duty of care for service providers, and contributes to staff expertise, as well as the stability and longevity of the workforce. (30, 33)

Organisations that show they value worker safety will retain a skilled workforce through organisational cultures that acknowledge and legitimise staff concerns about physical, psychological or reputational risk, and enact procedures that ensure physical and psychological safety for workers. (34) Cultural safety within the workforce is also important.

The relationship between organisations and the service system: integrated systems approaches to addressing DV

Government policy and funding provides system-wide authorising environments for collaboration across service streams, to promote accountability and safety.

A common language and conceptual framework of DV leads to accountability and support across organisations, sectors and service systems. (20)

Joined up funding streams to encourage a broadening of service focus will aid collaboration, and allow referrers to remain involved while families pursue service options that promote accountability and safety. (20)

System-wide practices of observing men in their fathering role and holding them to account - before, during and after, their involvement in behaviour change programs - are essential for families to be safe. (17)

Strong and flexible service pathways allow family members to access the specialist service system from universal health services - recognising that they may move in and out of universal services, depending on their need for specialist early intervention, response or recovery services (see figure 2).

Attention to transitions between service levels is important, particularly the development of "stepping down" services from therapeutic recovery, through DV-informed support to community involvement. (30)

Recommendations

Invest in early engagement work

1. A strong investment in organisational capacity and systems change to support culturally safe, holistic responses that can:
   - identify and engage with families early, while families are together and risks are moderate;
   - tailor to families' broader needs across all aspects of their lives, not just focused on safety and risk assessment and management;
   - tailor to the specific communities that may structure the context in which families are living.

Focus on children's safety

2. Prioritise responses that focus on reducing the intergenerational effect on children and young people.
3. Provide therapeutic services for infants from the beginning of life (or earlier), along with their protective parent (usually mothers).
4. Support children to be active agents in decision making, ensuring agency and choice is appropriate for age and development stage.
5. Facilitate responses to children and young people in their own right, while recognising that they may prefer to be seen with adults that they trust.
6. Recognise that 'safety' also refers to 'cultural safety'.
7. Increase support for parent-child relationship strengthening, recovery and healing, from infancy onwards.
8. Expand the provision of relationship-based responses, both group and individual services, including services for men who use violence that assess safety and incorporate support of children and their mothers.

Service viability and interconnection

9. Ensure ongoing funding certainty for relationship-based responses to children, women and men, so that service pathways and collaborative relationships can be built and sustained.
10. Develop funding strategies that enable therapeutic responses to provide or link with broader case support and management, to meet the holistic needs of service users. (Without this holistic support, therapeutic responses may be ineffective or service users may drop out).
11. Fund programs, taking into account the significant time taken for engagement and pre-program support in therapeutic responses for service users in complex circumstances.
12. Build a system which rewards information exchange and feedback loops between services and statutory systems, to ensure accountability, monitor safe fathering practice and support fathers to remain engaged in program responses.
13. Improve linkages between services and develop clearer referral pathways to support women, men, children and families experiencing complex circumstances that compound risk and undermine family safety - e.g. drug/alcohol dependence, mental health problems and DV.
14. Expand provision of specialist family violence support services that can liaise with primary and mental health care and provide more seamless avenues for 'warm referrals' from primary care, antenatal care, maternal and child health services, sexual and reproductive health care, and hospital emergency departments, at all stages of the referral pathway. This would include services for women, adolescents, children and men.

Building a strong and skilled workforce

15. Continue system-wide training and upskilling of workers in relation to DV and working with perpetrators
16. Recognise cultural competency as a core skill for all workers.
17. Continue building capacity in organisations and services to provide strengths-based support for their workforce, including:
    - Physical, psychological and cultural safety in the workplace
    - Provision of clinical supervision and support
    - Policies promoting staff retention

Future directions for research and evaluation

- Development of accountability mechanisms across the service systems, and the barriers and enablers to these.
- Evidence development through ongoing rigorous short and long term evaluations, to harness practice innovation aligned with academic knowledge and ensure sustainable change.
- Further investigation about why women seek help, and what helps them stay engaged with services.
- Further investigation about what helps men engage and stay engaged through very challenging programs.
- Further investigation of children and young people's experiences of treatment or programs responding to DV.
- Development of a better understanding about how young children influence their own recovery.
- Safe inclusion of fathers in all-of-family responses to DV.
- Engage people from culturally and linguistically diverse backgrounds, refugee, and Aboriginal and Torres Strait Islander backgrounds, in co-design of services and evaluation

Appendix:
Evidence-based all-of-family programs evaluated by Safer Families Centre

The table below summarises evidence-based programs for children, parents and carers, evaluated by the Safer Families Centre for safety and resilience. These include a universal preventative and early intervention program, programs that respond to DV as it is happening, and programs that focus on recovery and healing.

Some of these programs have been developed and evaluated overseas, some are locally designed. This summary outlines findings relating to program trials within the mainstream Victorian service system. A small number of families taking part were from culturally and linguistically diverse backgrounds, refugee backgrounds or Aboriginal and Torres Strait islander backgrounds.

Early Intervention
Family Foundations: A group or home-based program spanning several months across the ante- and postnatal period, and focusing on the 'parenting partnership' rather than the parents' intimate relationship. The program targets family conflict in general rather than DFV, and is therefore an early or preventative program. The effectiveness of the program has been established by US-based several RCTs. Two evaluations by SAFER researchers using mixed methods, including client satisfaction surveys, pre-post measures based on mothers' reports and interviews, established the feasibility and acceptability of both home-based and telehealth implementation of Family Foundations in Victoria. Findings suggest that maternal stress and anxiety symptoms decreased, and co-parenting support and parenting warmth increased following the program. (29, 35)
Responding to DV
Keeping Safe Together: A pilot program for families living with DV who want to work therapeutically together to end the violence. Separate services were provided to the caregivers (usually mothers and fathers) and the children, as well as family group sessions. Participation was limited to families where all members agreed to participate, and the level of violence was deemed low to medium risk. The program involved therapeutic services, support, education and linkages for all family member DV, men's behaviour change, children's therapy and family therapy services, with some co-location of staff. Results of the pilot study suggested that the program could offer a safe and empowering space, particularly for women and children. Children indicated that they felt safer and more confident and women's experiences were validated. Most men were engaged with the program and developed some level of insight into their behaviour and its impact on family members. (33) Further research is needed to evaluate the program's effectiveness.
Caring Dads: A group program for men who have abused, neglected, or exposed their children to DV. It seeks to develop fathers' ability to engage in respectful, non-abusive parenting with the mothers of their children. The program consists of a manualised group parenting intervention with a DV lens for fathers, systematic outreach to mothers to ensure their safety and freedom from coercion, and ongoing, collaborative case management of fathers by existing service providers and other professionals involved with fathers' families.

This evaluation built on several international evaluations indicating that completion of the program was associated with reduced risks to children by fathers using domestic abuse. A three-year triangulated analysis including fathers' self-reports, mothers' reports of fathers' behaviour, group observation, and interviews with group facilitators and referrers, suggests that the Caring Dads program piloted in Victoria has a positive impact on fathers' parenting and co-parenting practices. reduces the risk of children's further exposure to DV, and increases fathers' ability to identify the impact of their aggressive behaviour on their children.(17)

Safe & Together Addressing ComplexitY (STACY):

The STACY Project developed practitioner and organisational capacity to work collaboratively across services providing support to children and families living with DV where there were co-occurring parental mental health issues and substance use. The expertise of practitioners was capacity built through training and coaching by the US-based Safe & Together Institute, and then harnessed through Communities of Practice. Researchers used ethnographic and other research methodologies within an overall action research (practice-led or co-designed) methodology to investigate changes in professional practice, inter-agency working, and the organisational change necessary to support ongoing development. (20)

Guidelines to inform services at the intersections of DFV, mental health and substance misuse were developed. (34) Instituting an all-of-family approach in this area goes beyond individual professional practice with clients, involving organisational change and a complex, system-wide approach to bring diverse services into agreed upon ways of working collaboratively. For example, holding the perpetrator to account requires gathering information about the perpetrator from numerous sources.

STACY for Children: Study 1:

This study drew on data from Communities of Practice, surveys and interviews, collected as part of the STACY project (see above) and re-analysed them with a focus on children's needs and perspectives. (22) Practitioner skill, and confidence in their own ability to work with children, are essential components of services which recognise that children and young people are also impacted by DFV in their families, that they experience these family dynamics in ways unique to each individual, and find their own ways of surviving the trauma. This may involve organisations training staff, employing child specialists, or collaborating with services which specialise in working with children.

Recovery and Healing

RECOVER: Child-Parent Psychotherapy:

A relationship-based treatment for parents and young children who have been traumatised by violence, aiming to reduce child trauma symptoms and behavioural problems The goal of Child-Parent Psychotherapy (CPP) is to support and strengthen the mother–child relationship, which acts as the vehicle to restore the child's sense of safety, attachment, and emotional wellbeing. CPP consists of parent and child sessions and collateral, parent-only reflective sessions, offered weekly according to dyad needs. CPP treatment is for approximately six months but may be longer.

CPP has been found in several previous RCTs to be an effective dyadic treatment model for mothers and children exposed to IPV. This feasibility study and mixed-methods process evaluation found that is acceptable and feasible for this population and can be implemented into the Australian setting, in locations with established family violence system partnerships, service capacity to prioritise mental health and wellbeing responses for very young children, and strong clinical governance structures. Evidence-based, relational programs such as this one were found to be in high demand. However, a scarcity of suitably qualified therapists, a lack of focus on mental health services for young children were among systems barriers, and poor links with DV services, were all found to inhibit establishment of this program. (8)

Children and Mothers in Mind:

Children and Mothers in Mind (CMIM) is a therapeutic group program for mothers and pre-school children who have experienced DV in the past. It includes two evidence-based groupwork programs - Connections (psycho-education) and Mothers in Mind (psycho-education and playgroup-based parenting support) - as well as brokerage and ongoing casework with participants.

As part of a process evaluation, participants in post program interviews, identified improvement in the following areas: increased confidence in parenting and boundary-setting, increased understanding of the impact of DV on children and on their parenting, increased levels of self-compassion. These positive changes contributed to reported improvements in the mother-child relationship, which is key to children's well-being, and were also reported by mothers six months following the program. (30)

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