Submission to the Royal Commission into

Domestic and Family Violence

Prepared by
Dr Carmela Bastian
Professor Sarah Wendt
September 2024

Focus of submission

The provision of services for infants, children and young people who experience domestic and family violence.

Purpose

The purpose of this submission to the Royal Commission into Domestic, Family and Sexual Violence (DFVSV) is to highlight some key learnings that have emerged from several research projects at the intersection of child protection and domestic and family violence in South Australia which may be helpful to inform your decision making. These research projects were administered through and led by researchers from the Social Work Innovation Research Living Space (SWIRLS) at Flinders University[1]

The DFVSV has been asked to focus on four key areas. This submission will provide information for consideration that spans three key areas of consideration - ***Early intervention: Response, and Recovery and Healing.***

Introduction

Children and young people's exposure to domestic and family violence (DFV) is a recognised form of child abuse and neglect, nationally and internationally reflected in child protection legislations and practice guidelines (Bastian et al 2023; Campo 2015). DFV diminishes children's immediate wellbeing, corrodes their life chances, and contributes to cumulative harm including poor health, social, psychological, academic, and developmental outcomes. The recent landmark Australian Child Maltreatment study (Matthews et al 2023) identified that 62.2% of Australians have experienced maltreatment in their childhood with almost one quarter of those Australians experienced multiple types of child abuse and neglect where exposure to DFV was the most prevalent (Higgins et al 2023).

Children's experiences of DFV are a critical area for policy and practice development (Noble-Carr et al., 2020) and in Australia, this is reflected in The National Plan to End Violence Against Women and Children 2022–2032, which states that it is important to "Recognise children and young people as victim-survivors of violence in their own right and establish appropriate supports and services that will meet their safety and recovery needs" (COAG 2022, p. 21).

Despite the increasing recognition and evolving policy responses there continues to be a gap in the provision of services that respond to the safety and wellbeing of children and young people. Of concern is the Child and Young People (Safety and Support) Bill 2024, which references *harm,* (physical or psychological) due to exposure to DFV. We would argue that exposure to DFV causes *significant harm* and should have more appropriate crisis response in the service delivery landscape for children.

Background

During time spent employed at the Social Work Innovation Research Living Space (SWIRLS) at Flinders University, the researchers represented in this submission have been engaged in numerous research projects that focus on improving service responses and outcomes for infants, children, and young people at the intersection of DFV child protection. These research projects contribute to significant learning across the sector outlined as follows:

[1] SWIRLS was an academic approved research centre at Flinders, which has now been restructured. The researchers that conducted the research referred to in this submission, are now employed or represented at other universities.

Project Partner	Topic/Title	Date
Early Intervention Research Directorate	Child Protection pathways of children who experience domestic and family violence	2022
Early Intervention Research Directorate:	Building Collaboration at the intersection of domestic and family violence and child protection: KWY and DCP	2019-2022
Early Intervention Research Directorate:	Collaboration between Women's Safety Service SA and DCP	2019-2022
Early Intervention Research Directorate	The Hidden Families: Collaboration between women's shelters and child protection	2023
Department of Child Protection	Domestic and family violence within a child protection context: Policy and practice guidelines and online course	2018-2023
Department of Human Services	Safe and Well Kids program evaluation	2023
Channel 7 Children's Research Foundation	Child centred/child informed evidence-based practice framework (n progress)	2024

Key Evidence

We have collated key evidence from these research projects to support key recommendations outlined in this submission. This evidence is in four categories:

- Incidence of DFV in child Protection
- Children as victims of DFV in Shelters
- Collaboration as a way forward
- Work with children in DFV shelters invisible but vital.
- Need for the role of children's workers to integrated into DFV shelter infrastructure.

Incidence of DFV in child protection

The analysis of 4000 child protection notifications in DCP from the "Child Protection pathways of children who experience domestic and family violence" highlighted the following in relation to child protection responses for children who experienced DFV (Appendix 1):

- Nearly a quarter (23.5%, 939) of these notifications were screened in and associated with domestic and family violence (DFV) (23.5%), relating to (30.7%) 706 children.

- Children who had received one or more DFV-related notifications: were more likely to be less than 3 years of age and have recent contact with the Department for Child Protection (notified in the last 6 months); – were 16% less likely to have an investigation; children were 83% less likely to be investigated if that notification was related to DFV.

The research indicates that children who experience DFV are less likely to receive statutory intervention at their first point of contact. It was also found that children were slightly more likely (14%) to be renotified in the subsequent two years, children experiencing DFV are just as likely as

non-DFV concerns to have ongoing Child Protection contact (Sokolenko, Bastian, Wendt, & Abdullah (2022).

Collaboration as a way forward

The researchers facilitated a large-scale research project "Building Collaboration at the intersection of domestic and family violence and child protection". When DFV and child protection intersect there are challenges of risk management, uncertainty, volatility and multiple forms of violence and abuse. However, collaboration is viewed as an opportunity to work with families who want to stay together. Collaboration between child protection and domestic and family violence practitioners can be identified through indictors such as information sharing, referral, shared case planning, and shared case conferencing (Bastian, C. & Wendt S, 2023).

The research team implemented two service delivery prototypes each focussing on different areas being:

1. Culturally safe collaboration between KWY and the Department for Child Protection (Appendix 2)
2. Collaboration between the Department for Child Protection and Women's Safety Services SA (Appendix 3)

There was difference in success for the prototypes. The collaboration between KWY and the Department for Child Protection which focused on culturally safe collaboration identified effective ways of ensuring effective multi-agency service provision to children, young people and their families who experience complexity. Findings of the project showed aspects of practice that were beneficial for practitioners, child safety and family outcomes. A particular feature of the collaboration was that KWY provided a whole of family culturally responsive approach (i.e. working with the perpetrator, women and children) to domestic and family violence.

The collaborative service model between the Department for Child Protection and Women's Safety Services SA was met with high level commitment and enthusiasm, however significant practice challenges were identified. It emerged that WSSSA was working with a cohort of families they called the "hidden families' who were identified as women and children who were residing in WSSSA accommodation seeking safety and refuge from DFV but there continued to be child protection issues.

Children and young people were safe from DFV from which they sought refuge, but they continued to experience abuse and/or neglect from their mothers who were engaging in unsafe parenting practices consequential to the profound experience of trauma. In these circumstances and for the hidden families, WSSSA articulated that they often sought support, advice, and intervention from DCP however for many of the families DCP was unable to respond to such requests as the children were identified as "conditionally safe" and meeting threshold for statutory intervention.

A recent systematic integrative review of research on children in domestic and family violence shelters (28 scientific articles published between 1984 and 2021 showed that overall, children feel safe at the shelters, and they appreciate the playgrounds and activities offered by the shelter. The studies also showed the importance of acknowledging children's rights to support, education, recreational time, and social relationships, to improve their life situation at the shelter (Thunberg et al, 2022).

Children as Victim/Survivors of DFV in Shelters

In light of the identification of the "Hidden Families" the researchers conducted a case file review to understand the children and families in more details. Children enter shelters with complex needs due to the impacts of trauma consequential to the experiences of DFV, and women experience complex issues due to their own long-term trauma, which in many circumstances diminishes their parenting capacity.

In the Hidden Families research project (Appendix 4) which reviewed case files included 36 children, some of the key trauma impacts were identified:

- 88.2 % experienced homelessness
- 82.4% school issues (non-attendance; poor performance)
- 76.5% reported behaviour issues (withdrawn; aggressiveness; fearful)
- 76.5% mental/emotional distress (i.e. bedwetting; soiling)
- 70.6% disrupted relationships inability to settle or concentration and learning difficulties.
- 70.6% disrupted sibling relationships and separation anxiety, maternal alienation, parent-child conflict, self-harm and suicidal ideation, parentification of children, diagnosis of PTSD, risk taking, and engagement in criminal behaviours.

In reviewing the case files, it was found that there is a shift in practice focus from being adult centred to be more family focused however not resourced to do so. Case file analysis identified that:

> "*Children and their mothers were provided safety planning, risk assessment, advocacy, practical assistance, housing support, referrals, outreach and liaison with police. Some counselling and referrals were specifically provided to children. There was limited capacity to provide specialist therapeutic interventions for children in the DFV shelters, so referrals were made to external services. Practitioners in the DFV services also found it necessary to contact statutory child protection in response to impaired parenting practices whilst residing in the DFV shelters*" (Bastian et al 2024).

This research also found:

- Statutory child protection is focused on addressing immediate harm to children and achieving safety through change of family circumstances, and women's shelters provided this refuge from the perpetrator.

- Domestic and family violence shelters receive funding to respond to adults and are not resourced to work with children experiencing complexities as victims/survivors of DFV, and to work with children and their mothers to establish safe parenting (Bastian et al (2024)

Children's work invisible but vital

Following from the projects focusing on building collaboration at the intersection of child protection and domestic and family violence, the researchers set out to further explore and understand service delivery for children and young people who sought services from DFV shelters. One project focused on the evaluation of the ***Safe and Well Kids Program*** and ***Implementing a child-centred child-informed practice framework (in progress)*** children specific service delivery (Appendix 5) and the other was focussed on designing child centred practice framework for future service delivery (Appendix 6).

The following findings emerged from the evaluation of the **Safe and Well Kids Program:**

- Parents expressed feeling more confident as a parent; more connected to their children; more attuned to their needs; able to engage in discussions regarding the children's feelings, understand their behaviours; support them to regulate their emotions; and more able to set boundaries and attend to day-to-day parenting responsibilities.

- There was evidence of significant improvements in the children's overall wellbeing, emotional literacy, and regulation for both the mothers and their children; the children developed skills in recognising their emotions, and developed increased confidence and trust that their mothers would respond to their needs.

- There was evidence of strengthened family relationships, emotional safety, safety planning (including for visitations with father) and education and discussions about DFV.

- Legal health checks were conducted, and advice was given across a range of areas which included family law, property settlements, leasing arrangements, advice about intervention orders and safety, complying with pre-court actions, mediation, and retrieval of property.
- There was improved cultural connections and provision of culturally responsive services were identified, and

- An important outcome of these projects were the positive outcomes for the children and families because of existing structures and expertise in women's shelters. The demographics and demands experienced by the women's shelters are changing. It is an opportune time to build workforce and resource capacity within an existing service structure that is DFV informed and trauma responsive. Implementing a child-centred and child-informed practice approach within shelters and employing specialists will ensure that children and young people will no longer be regarded as the untended, forgotten, or silent victims of DFV" (Bastian et al 2023)

The research project funded by the ***Channel 7 Children's Research Foundation*** is still in progress. Practitioners, women and their children were interviewed to develop and implement a child centred and child informed practice framework. Some of the preliminary findings identified as that:

- There is an increasing number of children and young people being accommodated in domestic and family violence shelters however allocation of funding and resources are allocated based on traditional adult centred model.

- Practitioners employed within the domestic and family violence shelters are required to respond to the complex safety and wellbeing needs of infants, children and young people and their mothers/carers. The work that is conducted with children and young people is largely invisible, not funded and its complexity and importance unrecognised.

- Resourcing, partnering, and building capacity within the existing structures and expertise within domestic and family violence shelters to respond to needs of children and young people as victims of domestic and family violence has significant potential for collaboration with child protection. A recent systematic integrative review of research on children in domestic and family violence shelters (28 scientific articles published between 1984 and 2021 showed that overall, children feel safe at the shelters, and they appreciate the playgrounds and activities offered by the shelter. The studies also showed the importance of

acknowledging children's rights to support, education, recreational time, and social relationships, to improve their life situation at the shelter (Thunberg et al, 2022).

- A way forward to responding to the increasing numbers of children and young people who experience DFV is to take advantage of existing structures and expertise in women's shelters. The demographics and demands experienced by the women's shelters are changing. It is an opportune time to build workforce and resource capacity within an existing service structure that is DFV informed and trauma responsive. Implementing a child-centred and child-informed practice approach within shelters and employing specialists will ensure that children and young people will no longer be regarded as the untended, forgotten, or silent victims of DFV. (Bastian, Wendt, Rowland & Elder, 2023)

Key Learning

- Children and young people who are the subjects of child protection notifications do not always meet the threshold for statutory intervention therefore exacerbating their experience of domestic and family violence and trauma.

- The lack of a child protection response may be further impeded in the future as the draft South Australian Children and Young People (Safety and Support) Bill 2024 identifies under Section 4 (1) that: *For the purposes of this Act, a reference to harm will be taken to be a reference to physical harm or psychological harm (whether caused by an act or omission) and, without limiting the generality of this subsection, includes such harm caused by sexual, physical, mental or emotional abuse or neglect or* ***exposure to domestic violence.***

- There are an increasing number of children and young people being accommodated in domestic and family violence shelters however allocation of funding and resources are still allocated based on traditional adult centred model.

- Practitioners employed within the domestic and family violence shelters are required to respond to the complex safety and wellbeing needs of infants, children and young people and their mothers/carers. The work that is conducted with children and young people is largely invisible, not funded, and its complexity and importance unrecognised.

- It is an opportune time to build workforce and resource capacity within an existing service structure that is domestic and family violence informed and trauma responsive. Implementing a child centred and child informed workforce into women's shelters is perhaps the way to bridge collaboration between children protection and domestic and family violence.

Recommendations

- That child protection notifications involving children and young people who live in a context of domestic and family violence be "deviated" to a targeted service for early intervention.

- That collaboration and professional communication pathways be established between the Department for Child Protection and domestic and family violence to enhance the safety and protection of children and young people.

- That domestic and family violence shelters be provided additional resources and/or funding to employ children's practitioners who have the necessary knowledge, skills, and commitment to respond to children and young people from point of crisis right through to provision of therapeutic intervention and, the employment of children's workers be supported by a governance structure.

- Increase workforce and resource capacity within an existing service structure that is domestic and family violence informed and trauma responsive.

- Implement a child centred and child informed workforce into women's shelters as the way to bridge collaboration between children protection and domestic and family violence.

Thanks for your time and consideration of this submission. Please do not hesitate to contact me should you wish to discuss further

[redacted]

Dr Carmela Bastian (BSW; MSW; PhD)

Senior Lecturer in Social Work

Flinders University

[redacted]

Appendices (See Uploads)

Appendix 1: Child Protection Pathways of children who experience domestic and family violence

Appendix 2: Building collaboration at the intersection of domestic and family violence and child protection: KWY and DCP

Appendix 3: Collaboration between Women's Safety Services South Australia and the Department for Child Protection

Appendix 4: The Hidden Families: Collaboration between women's shelters and child protection

Appendix 5: Safe and Well Kids: An evaluation

Appendix 6: Channel 7 Research Foundation Practice Framework (Draft – in progress)

References

Bastian, C, Wendt, S, Rowland, G, & Elder, A Improving Service Responses for Children and Young People Who Experience Domestic and Family Violence: A Way Forward, *Australian Social Work,* online 8 Nov 2023

Bastian, C & Wendt, S, Collaboration Between Child Protection and Domestic and Family Violence: A Case File Review *Australian Social Work*, Vol 76 No: 2 186 – 202.

Bastian, C, Wendt S, Cunningham, T & Bromley, A, In Press (2024) Understanding services provided to children in DFV shelters: exposing the "invisible" work British Journal of Social Work (In Press)

Campo, M. (2015). Children's exposure to DFV - Key issues and response (CFCA Paper No. 36, Issue. A. I. o. F. Studies. https://aifs.gov.au/cfca/publications/childrens-exposure-domesticand-family-violence

Higgins, D. J., Matthews, B., Pacella, R., Scott, J. G., Finkelhor, D., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D. M., Haslam, D. M., Malacova, E., & Dunne, M. P. (2023). The prevalence and nature of multi-type child maltreatment in Australia. Medical Journal of Australia, 218(S6), S19–S25. https://doi.org/10.5694/mja2.51868 (Higgins et al., 2023).

Matthews, B., Pacella, R., Scott, J. G., Finkelhor, D., Meinkck, F., Higgins, D. J., Erskine, H. E., Thomas, H. J., Lawrence, D. M., Haslam, D. M., Malacova, E., & Dunne, M. P. (2023). The prevalence of child maltreatment in Australia findings from a national survey. Medical Journal of Australia, 218(1), S1–S51. https://doi.org/10.5694/mja2.51051

Thunberg, S., Vikander, M., Arnell, L (2022) Children's Rights and Their Life Situation in Domestic Violence Shelters—An Integrative Review, Child and Adolescent Social Work Journal, https://doi.org/10.1007/s10560-022-00900

Wendt,S, Bastian, C, Jones, M., Building Collaboration with Child Protection and Domestic and Family Violence Sectors: Trialling a Living Lab Approach, *British Journal of Social Work* (2021) Vol 51 p 692- 711

Appendix 1

Flinders University

Social Work Innovation Research Living Space

Child protection pathways of children who experience domestic and family violence

SWIRLS

Social Work Innovation Research Living Space

- **Dr Elysia Sokolenko**
- **Dr Carmela Bastian**
- **Professor Sarah Wendt**

November 2022

Contents

Acknowledgements

The report must begin with an acknowledgement of the children and young people who are central to this report. This report articulates the journeys and experiences of those children and young people who were harmed or were at risk of harm and were in receipt of services from the child protection system in South Australia. The mapping of their journeys and experiences informs understanding and service development for children and young people who experience complexity. It is for them that we engage in this work.

We acknowledge this work was conducted on the lands of Kaurna people, and thank our Aboriginal and Torres Strait Islander leaders, colleagues, and families for their partnership and support.

We thank the Early Intervention Research Directorate (EIRD) within the Department of Human Services, Government of South Australia, for funding and supporting this research. Particularly, thank you to Dr Dana Teusner for providing expertise in analytical methods.

We also thank the Department for Child Protection (DCP), particularly Mel Bradley, Jay Mullen, Julie Petersen, and other staff, for facilitating access to data, providing ongoing support and comments on the final report.

Government of South Australia
Department of Human Services

Government of South Australia
Department for Child Protection

Executive Summary

The Early Intervention Research Directorate (EIRD) Postdoctoral Fellowship Program is working with Social Work Innovation Research Living Space (SWIRLS) at Flinders University. Professor Sarah Wendt and Dr Carmela Bastian have been working together with key stakeholders to develop understandings and co-design collaborative response to support children and families experiencing both domestic and family violence and child protection concerns. Dr Elysia Sokolenko joined the team and produced findings that are the focus of this report. The focus of this report is to begin building a picture of pathways and outcomes for children and families who experience domestic and family violence in the Southern Metropolitan region.

De-identified administrative data was drawn from the Department for Child Protection's (DCP) case management system and was used to provide a descriptive account of the journey and responses experienced by children who were subjects of child protection notifications in the Southern Metropolitan Region. This will broaden understanding of how domestic and family violence (DFV) is recognised and responded to in the context of statutory child protection responses.

Understanding these pathways will provide context to the broader research agenda and facilitate the identification of potential collaborative points for future investment. In doing so, this project aimed to provide improved outcomes for children and families at the intersection of DFV and child protection.

Domestic and family violence (DFV) is a complex and multifaceted issue that impacts many families who receive services from the Department for Child Protection (DCP). DCP is committed to best practice and recognises research plays a critical role in continuous improvement. DCP staff require contemporary best practice advice to ensure they respond effectively to families impacted by DFV to support child safety. In recent years, DCP has strived to develop DFV practice and has implemented several initiatives to support this.

The report highlights the critical importance of early intervention, referral pathways and specific services for children experiencing violence. DCP acknowledges the need for a connected system informed by contemporary and accurate data for families where violence is an issue. This will aid services to provide effective partnership with the survivor to create safety for children and young people. Significant reform has already occurred to strengthen the services provided to families impacted by DFV. This includes the introduction of the *Children and Young People (Safety) Act 2017*, which increases focus on early intervention and referral to specialist services. The introduction of new service pathways, such as the first

iterations of the Child and Family Assessment and Referral Network and Multi-Agency Assessment Unit (disestablished in 2019) and referrals to State Authorities support more effective and targeted early intervention for families impacted by DFV.

As the report echoes, there is a need to improve the identification of DFV related concerns to ensure children and families receive appropriate services. In 2018, the Structured Decision-Making screening tool was updated to better identify DFV concerns at the point of notification. This included the addition of 'injury resulting from domestic violence incident (PO4)' and 'likelihood of harm – DFV (LO5)'. This has improved DCP's data collection and supported increased visibility of DFV.

While several initiatives have already been implemented, DFV informed practice is a priority for DCP and will continue to be at the centre of practice learnings and improvement activities to ensure children and young people are supported to grow up safe, happy, healthy, and nurtured to reach their full potential. The findings of this report provide an excellent opportunity for continued commitment to improve practice and outcomes for children and families. DCP welcomes partnership with Flinders University to provide research translatable practice findings.

Key findings

- 4,000 notifications were recorded in the Department for Child Protection for 2,301 children who resided in the Southern Metropolitan Region in 2016.
- Nearly a quarter (23.5%, 939) of these notifications were screened in and associated with domestic and family violence (DFV) (23.5%), relating to (30.7%) 706 children.
- Of the 706 children reported for DFV-related concerns, 319 (45.2%) children were only reported for DFV-related concerns, 387 (54.8%) children were reported for a DFV and other non-DFV concerns.
- Of all 2,301 children, 18.7% (395) had at least one investigated notification in 2016. Almost two thirds (61.3%, 242) of those children had a substantiation or were assessed as having experienced harm.
- Compared to children who were the subject of a non-DFV related notification (during 2016), children who had received one or more DFV-related notifications:
  - were more likely to be less than 3 years of age and have recent contact with the Department for Child Protection (notified in the last 6 months).
  - were 16% less likely to have an investigation, and among children who only had one notification in 2016, children were 83% less likely to be investigated if that notification was related to DFV. This indicates that children who

experience DFV are less likely to receive statutory intervention at their first point of contact.

  - Children were slightly more likely (14%) to be renotified in the subsequent two years, but this result did not persist (not statistically significant) after controlling for demographics and child protection history. Therefore, children experiencing DFV are just as likely as non-DFV concerns to have ongoing CP contact.
  - Children who were the subjects of notifications were 33% more likely to be referred to a service by DCP, but overall, the proportion of children referred was low (5.1%) and in 2016 there were no records of referrals for DFV specific services which may be more related to the availability of data rather than practices.
  - Receiving an OOHC placement did not vary by whether the child had a DFV-related notification.
- Among the children who were the subject of an investigation:
  - children with a DFV-related notification were 48% more likely to be the subject of a substantiation than children investigated for non-DFV related concerns. Indicating that while children with DFV-related concerns did not appear to be prioritised for a statutory response and investigation, when investigated it appears that children are more likely to have substantiated experiences of harm indicating a higher likelihood of cumulative harm.
- Aboriginal and Torres Strait Islander children were 29% more likely to have a DFV-related notification in 2016. Further analysis examining number of notifications received indicated that there was little difference of having a DFV-related notification among children who had only received one notification during the year. This broadly indicated that Aboriginal and Torres Strait Islander children may be more likely to have a DFV-related notification because they are more likely to be renotified and receive multiple notifications during the year.

1. Introduction

The Early Intervention Research Directorate (EIRD) Postdoctoral Fellowship Program is working with Social Work Innovation Research Living Space (SWIRLS) at Flinders University. Professor Sarah Wendt and Dr Carmela Bastian have been working together with key stakeholders to develop understandings and co-design collaborative response to support children and families experiencing both domestic and family violence and child protection concerns. Dr Elysia Sokolenko joined the team and produced findings that are the focus of this report. The focus of this report is to begin building a picture of pathways and outcomes for children and families who experience domestic and family violence in the Southern Metropolitan region.

Administrative data that was aggregated and de-identified was drawn from the Department for Child Protection's (DCP) case management system and was used to provide a descriptive account of the journey and responses experienced by children who were subjects of child protection notifications in the Southern Metropolitan Region. This will broaden understanding of how domestic and family violence (DFV) is recognised and responded to in the context of statutory child protection responses.

Understanding these pathways will provide context to the broader research agenda and facilitate the identification of potential collaborative points for future investment. In doing so, this project aimed to provide improved outcomes for children and families at the intersection of DFV and child protection.

Context

The data analysis presented in this report are inclusive of children's journeys and responses by the Department for Child Protection to their notifications during the period of 2016-2018 which has been a period of significant reform for the agency and the child protection system in South Australia. It is important to understand this context as it facilitates insight into the prevailing conditions in which child protection assessments and responses were provided to the children.

The findings of the Child Protection Systems Royal Commission were delivered by the Hon Margaret Nyland AM August 2016 following a momentous experience for the child protection system in South Australia. The inquiry revealed some of the following findings: the system was overwhelmed by the volume and complexity of work and lack of resources to respond to the increasing need until removal was necessary; significant deficiencies existed across the system as a result of under-investment; the system is an outdated incident based response, leading to the lack of sophisticated responses required for children and young people

experiencing chronic neglect and cumulative harm; system responses were not evidence based and therefore concerns about whether interventions offered to children and families were making a real difference, and lack of investment in the workforce who were responsible for working with children, young people and families experiencing complexity (Nyland, 2016).

The Child Protection Systems Royal Commission (Nyland, 2016) provided the foundation for the implementation of the reform agenda *Child Protection: A Fresh Start* (Government of SA, 2017). The reform agenda centred on the establishment of a new statutory child protection system including legislative reforms, improved governance, a new department, improved model to receive and respond to notifications, out of home care and improved complaints, and review processes. During the reform period there was also increased focus on improving practice in relation to children and young people and their families who experience complexity including domestic and family violence and are notified to the child protection system.

The commitment to improve practice in relation to domestic and family violence in the context of child protection was demonstrated by DCP Executive commissioning researchers (Professor Sarah Wendt, Dr Carmela Bastian, and Dr Michelle Jones) in 2018 from the Social Work Innovation Research Living Space (SWIRLS) at Flinders University to engage with practitioners on this issue and support practice change. Qualitative research was undertaken inclusive of practitioners from within DCP and domestic and family violence agencies recommending that: there was a need for the development of a consistent department-led approach to domestic and family violence that is gender sensitive, trauma informed, and culturally safe; a need for collaboration is required at practitioner, team, and organisational levels, and training and development in domestic and family violence must be ongoing and considered core business. The research informed the development of a practice paper which is currently being implemented with the support of the research team from Flinders University. In addition, DCP has partnered with KWY, Women's Safety Service SA and Flinders University in a project to build collaboration at the intersection of domestic and family violence and child protection which is funded by the Early Intervention Research Directorate. In 2018, the Structured Decision-Making screening tool was updated to better identify DFV concerns at the point of notification. This included the addition of 'injury resulting from domestic violence incident (PO4)' and 'likelihood of harm – DFV (LO5)'. This has improved DCP's data collection and supported increased visibility of DFV.

One of the findings of the pathways analysis demonstrates little change in the service responses received by children and young people who were subjects of notifications in cohorts in 2016 and 2018. This is indicative that practice change in large and complex

systems such as child protection is not realised immediately but in subsequent years. Sweeping changes and reform in a complex agency and system such as child protection must occur within the day-to-day realities of the organisation and for the practitioners where high workloads persist and there continues to be increase in the numbers of children and young people who experience harm or at risk of harm.

How notifications are assessed

All notifications received by the Child Abuse Report Line or call centre practitioners where a decision is made as to whether notifications of alleged abuse are either “screened in” or “screened out”. Those children and young people who are subjects of notifications that are “screened out” are assessed as not meeting the threshold for a service from the statutory child protection agency Families SA (2016) and Department for Child Protection. For those notifications that are screened in a priority rating is assigned to determine how quickly a response should be provided.

Notifications that are screened in include allegations of physical, sexual, emotional abuse and/or neglect and decision making is informed by the Structured Decision-Making Tool (SDM) and then forwarded to the relevant offices for intervention. Screened in notifications are sent to the intake or Assessment and Support Teams for a response that is reflective of the level of risk experienced by the child and/or young person. If an investigative response is provided there is a decision as to whether abuse or neglect is substantiated, or the child/young person has experienced harm. Within South Australia and nationally the most common form of abuse substantiated includes emotional abuse (54%) (AIHW, 2020) which is reflective of the increasing prevalence of children and young people identified as living in contexts of violence (ABS, 2016; AIHW, 2018). Outcomes of investigations will determine whether ongoing intervention is provided to the child, young person and their families (See Appendix A). For example, a child or young person who has been harmed is more likely to be provided protective intervention that a child or young person where harm was not substantiated.

Notifications are screened out for several reasons including:

- not reaching the threshold for abuse and/or neglect or notifier lacks credibility.
- there are no grounds for intervention because the information is historical, another agency is responding, and child or young person are conditionally safe.
- there is an active agency in place meeting the safety needs of the child and family.
- an adolescent is the subject of the notification, and they are at risk from their own behaviour or other sets of circumstance,

- the alleged perpetrator is not within the child's immediate family environment and the carer is responsive to the child's safety needs, and
- an unborn child prior to 24 weeks gestation.

As discussed in the Nyland (2016) some the notifications that are screened out may not warrant intervention by the statutory organisation however referrals are made to other agencies to respond to the safety and wellbeing of the children and/or young people. The Nyland Review (2016) conducted a review of 60 screened out notifications and concluded that there was an inconsistent application of threshold for intervention and that the children and young people who were subjects of approximately 90% (54) notification required a response. In conversation with senior management staff in DCP, notifications that are screened out provide opportunities where children and young people and their families may be diverted from statutory to non-government services as an early intervention response.

There are associated complexities in responding to child protection notifications where children have experienced domestic and family violence. The impact of domestic and family violence on children is now better understood, and policy responses have been formed. However, how child protection systems respond to domestic and family violence as a presenting issue, and how child protection systems interact with domestic and family violence specialist services, is less clear (Buckley, 2018). Similarly, how specialist domestic and family violence services, with their focus traditionally on adults, respond to the needs of children is an important issue (Buckley, 2018). Responding to domestic and family violence requires a multiagency response as women and children are both victimised, and perpetrators need to be engaged in therapeutic and/or criminal justice responses.

2. Methods

2.1 Data source

Quantitative data was extracted from DCP's case management data system for all children who were the subjects of child protection notifications in the Southern Metropolitan Region of Adelaide (Noarlunga, St Mary's, or Marion DCP offices) from July 2015 – December 2018. A record of notifications, alleged grounds for notifications, substantiated grounds, OOHC placements and referral to services was received each in a separate database (i.e. 5 separate files). Each item within all datasets contained a unique identifier for individual children. This identifier was a coded version of that used by DCP, so that the data provided to the researchers was de-identified. Demographic information (date of birth, sex, Aboriginal and/or Torres Strait Islander people's identity) was provided for each child. Children with a notification from January – December 2016 formed the population of interest. Events that

occurred from July 2015 – December 2015 and from January 2017 – December 2018 were used to map children and young people's prior and subsequent experiences, respectively, through the child protection system.

2.2 Pathway diagrams

One aim of this report was to track the journey of each child through the DCP and present their journey in a pathway diagram. The first step to do this was to assess the outcomes for each notification. There are several possible outcome decisions for a notification made by DCP. Notifications in this study were assigned to one of the following broad outcome categories:

- Screened-in, investigated, and substantiated.
- Screened-in, investigated, and not substantiated.
- Screened-in, and not investigated.
- Screened out.

A notification was categorised as screened-in if assigned 'CP Matters' as the screen decision in the DCP case management system and screened-out if assigned any other value (e.g., 'Report on Unborn', 'No grounds for intervention', etc.). A notification was categorised as investigated if assigned 'Investigation' as the action description, and not investigated if assigned any other value (e.g., 'Dealt with by other means', etc.). A notification was considered substantiated if the investigation outcome value was 'Substantiated', and not substantiated if given any other value (e.g., 'Investigation in progress', 'Not substantiated' etc.).

For the period between 2016 - 2018, there was no specific identifier code for the experience of DFV within the DCP case management system. In consultation with DCP, the decision was made to identify DFV concerns through alleged grounds codes. The alleged grounds codes were matched to the respective notification using the intake phase identification number. A notification was associated with DFV if it had one of the following alleged grounds:

- RE05 – Significant risk of emotional abuse – domestic violence
- RN05 – Significant risk of neglect – domestic violence
- RP05 – Significant risk of physical abuse – domestic violence
- PHY4 – Injury resulting from domestic violence incident

It is important to note that only screened-in notifications are assigned alleged grounds. On this basis, it was not possible to determine whether a screened-out notification was associated with a DFV concern.

The next step was to collate the notifications for each child in 2016. It is not uncommon for children to be reported to DCP multiple times in a year, and for those notifications to have different outcomes. For example, one child's first notification was screened in but not investigated, and their second was investigated and substantiated. In these cases, a decision needed to be made about what arm of the pathway flowchart to assign each child. Others that have performed similar analyses have based this decision on the outcome of one notification, whether it be the first for that child or one selected at random (Shlonsky et al. 2019). This, however, has its limitations. Going back to the example above, taking this child's first notification would lead to the severity of this child's experience being underestimated. To mitigate this, we chose to assign children to an outcome based on their *deepest contact* with DCP in the period of interest. Deepest contact here, referring, to the most severe outcome experienced. To again return to the example, this child would be assigned to the outcome investigated and substantiated, capturing the full extent of their experience.

To further understand the experience of each child, the number of times each child was placed in in out of home care (OOHC) and/or referred to a service was counted. The number of children in each outcome category having an OOHC placement and/or service referral was recorded. Of note, OOHC placements and service referrals did not have an intake phase ID, as with alleged grounds. This means they could not be linked to a specific notification however provided some indication of the experiences of the children. This process was repeated for children having a renotification in 2017-2018, and an investigation and/or substantiation in that period.

The key question of this project was whether the child protection pathways differ for children who have experienced DFV. To do this, separate pathways diagrams were then constructed for children with and without DFV concerns in 2016. Children with at least one screened-in notification with a DFV alleged grounds were allocated to the DFV chart. Children with at least one screened-in notification but no notifications with a DFV alleged ground were allocated to the non-DFV concern chart.

This same procedure was used to examine data from 2018. This was done to determine whether the policy changes and reform agenda introduced in 2016 had an impact on

practice responses for children and young people who experienced domestic and family violence.

2.3 Statistical analysis

Regression models assessed the associations between having a notification for a DFV concern and each of the child protection outcomes. Demographic and risk profile variables were included as other explanatory variables to control for their influence on each outcome.

The outcomes were (all yes/no):

- received Investigation 2016,
- received Substantiation 2016,
- received OOHC placement 2016,
- received referral to services 2016,
- received Re-notification 2017-18,
- received Investigation 2017-18,
- received Substantiation 2017-18.

The demographic variables:

- Sex (female compared to male),
- Age (at end of 2016),
- Aboriginal and/or Torres Strait Islander peoples (compared to non-Indigenous).

The risk profile variables for the 2016 outcomes were:

- Notification received July – Dec 2015
- Investigation received July – Dec 2015 (yes compared to no),
- OOHC placement either beginning or ending July – Dec 2015
- Referrals to services received July – Dec 2015
- Report on Unborn July – Dec 2015
- Notifications 2016 (1 compared to ≥2 when model could not be stratified).

The risk profile variables for the 2-year follow-up outcomes were:

- Investigation received2016
- OOHC placement beginning in 2016
- Referrals to services 2016
- Report on Unborn 2016

For each outcome, DFV-related notification in 2016 was the main explanatory variable (yes/no). Children with multiple notifications would have a higher chance of having a DFV-related notification and all other outcomes, such as a substantiation that year. This increases the potential for observation bias (i.e., more notifications, more observations, higher likelihood of recording DFV). To control for this potential bias, models were also produced stratified by number of notifications received during 2016. Separate models for all children, children with 1 notification and those with 2 or more notification during 2016. Due to small numbers, stratified models could not be produced for some outcomes. In these cases, number of notifications (1 vs 2 or more) was used as a risk profile predictor.

As with the pathway diagrams, this same procedure was used for data in 2018. Given the dataset only went up to 2018, re-notification, as well as subsequent investigation and substantiation, could be not predicted here as was done when looking at 2016.

3. Findings

3.1 Demographics

A higher percentage of the children with DFV concerns were under 3 years of age (25.6%) compared to that for the children with non-DFV concerns only (15.5%). A higher percentage of the children reported for DFV concerns were Aboriginal and Torres Strait Islander peoples (21.2%) compared to that for non-DFV concerns (14.7%). A higher percentage of children reported for DFV concerns had a notification to DCP in the 6 months prior (July – Dec 2015; 29.5%) compared to that for the children with only non-DFV concerns (22.4%).

Table 1. Characteristics of children reported for DFV and non-DFV concerns in 2016.

	DFV concerns (N=706)		**No DFV concerns** (N=1,402)		**All children** (N=2,301)	
	N	**%**	**N**	**%**	**N**	**%**
Age (at end of 2016)						
<1	54	7.7	85	6.1	165	7.2
1 - 2	126	17.9	130	9.4	275	12.0
3 - 5	138	19.6	195	14.0	355	15.4
6 - 11	249	35.4	457	32.9	751	32.6
12 - 15	101	14.3	348	25.1	473	20.6
≥16	36	5.1	173	12.5	227	9.9
Unknown	2	0.3	14	1.0	55	2.4
Sex						

Male	353	50	663	47.3	1099	47.8
Female	350	49.6	729	52.0	1147	49.8
Unknown	3	0.4	10	0.7	55	2.4
Aboriginal and/or Torres Strait Islander peoples						
Yes	150	21.2	206	14.7	405	17.6
No	512	72.5	1075	76.7	1711	74.4
Unknown	44	6.2	121	8.6	185	8.0
CP event July – Dec 2015						
Yes	208	29.5	314	22.4	613	26.6
Report on Unborn	16	2.3	18	1.3	34	1.5
No	498	70.5	1088	77.6	1688	73.4

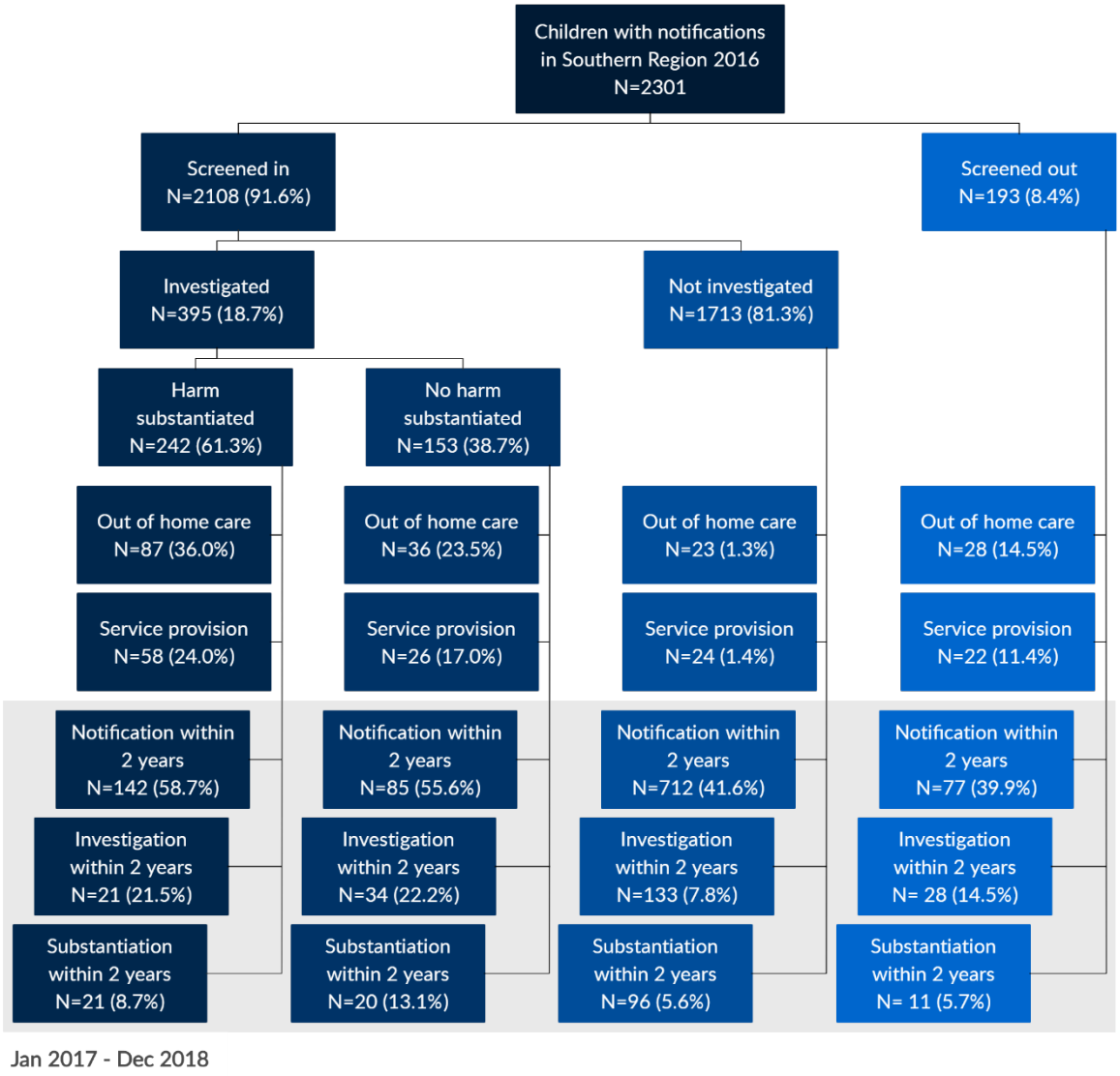
3.2 Pathway diagrams

There were 4,000 notifications recorded in the DCP case management system for children and young people residing in the Southern Metropolitan Region of Adelaide in 2016. Of those notifications, 18.9% (757) were screened out, 65.6% (2,626) were screened in but not investigated, and 15.4% (617) were screened in and investigated. These notifications related to 2,301 children. Of those notifications investigated, 8.5% (340) did not have a substantiation, and 6.9% (277) had a substantiation. In 2016-17, 21,546 notifications were recorded for South Australia (*Child Protection Australia 2016-17*). Of those notifications, 19% (4,094) were investigated and 7.7% (1,661) were substantiated. Overall, the percentage of notifications that were investigated across Australia is more than double than South Australia, but for the Southern Region of Adelaide is lower compared to the state. The percentage of notifications with substantiations across Australia is more than double than for South Australia, but there is negligible difference between that for the whole state and specifically the Southern Region of Adelaide.

3.2.1 Pathways for all children

Figure 1 shows the deepest contact each child experienced with DCP in 2016, as well as that during the 2-year follow up period. Results show that 8% of children were screened out. It should be noted that notifications which do not meet the threshold for further intervention are not allocated geographically to a region but are recorded against the DCP Call Centre. Given almost two thirds (64%) of children in this study only had 1 notification and that not all screened-out notifications are allocated to the Southern Region; for these reasons, this group will not be considered further. Of the 2108 children who were subjects of screened in notifications, 19% (395) of children were the subject of an investigation. Of those 395 children, 61% (242) were found to have experienced harm and notification substantiated. The percentage of children who experienced OOHC ranged from 36% to 1% for children that had a substantiation and those not investigated, respectively. Similarly, the percentage of children who were provided a service ranged from 24% to 1% for those same groups of children. A higher percentage of children who were the subjects of investigation had a placement in OOHC and were provided a service by DCP, compared to those not investigated. The same can be said for notifications, investigations, and substantiations in a 2-year follow-up period.

Figure 1. Child protection pathway (2016 -2018)

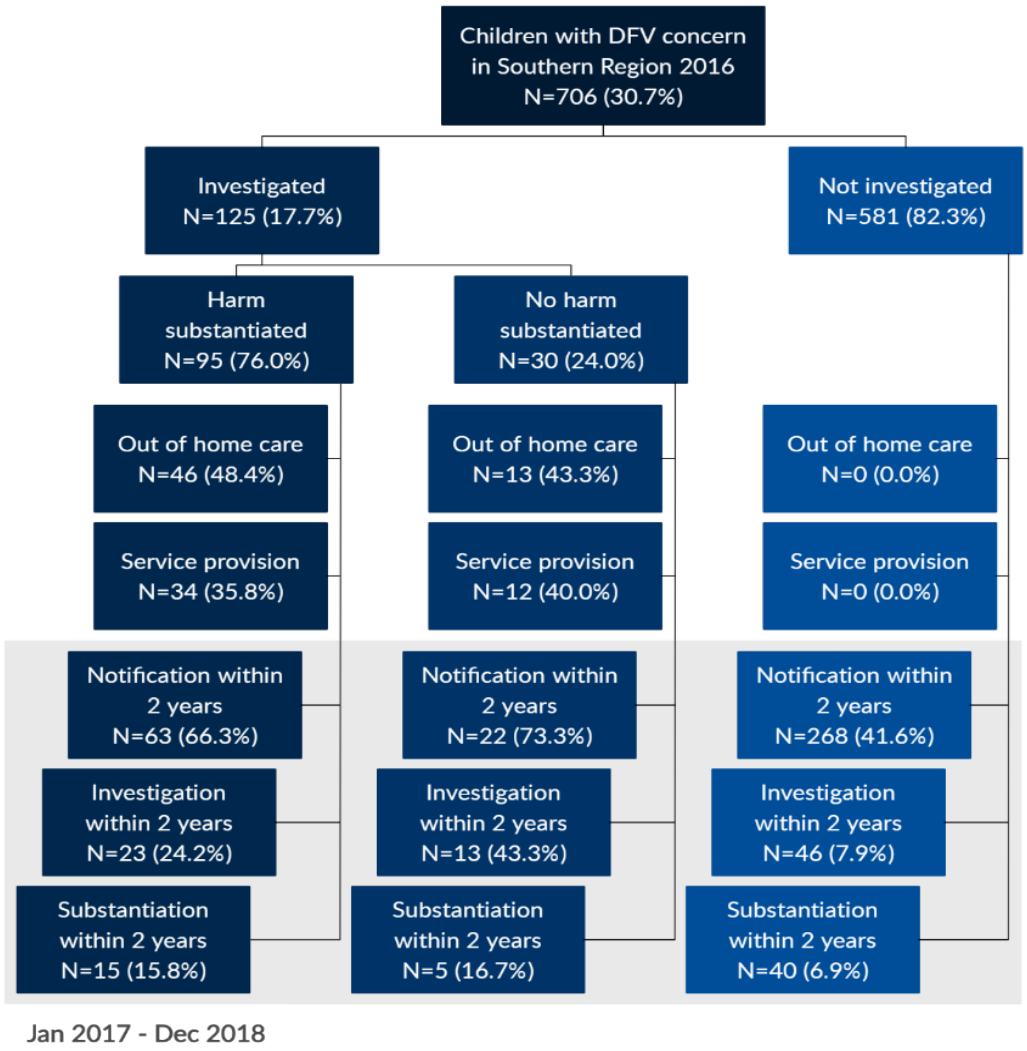


3.2.2 Pathways for children with DFV concerns in 2016

Figure 2 shows the deepest contact for each child with at least 1 notification with a DFV concern in 2016, as well as that during a 2-year follow-up. Results show that of the 706 children who were screened-in due to experiences of domestic and family violence, 18% (125) of children were the subjects of an investigation. Of the children with a DFV concern who were investigated, 76% (95) had a substantiation. The percentage of children who were placed in OOHC ranged from 48% to 0% for the children who had a substantiation and those not investigated, respectively. Similarly, the percentage of children who were referred to a service ranged from 36% to 0% for those same groups of children. A higher percentage of children who were investigated had a placement in OOHC and were provided a service, compared to those not investigated. The same can be said for notifications, investigations,

and substantiations in a 2-year follow-up period. Overall, 50% of children reported for a DFV concern had another notification in the 2-year follow-up period.

Figure 2. Child protection pathways for children who had experienced DFV 2016-2018

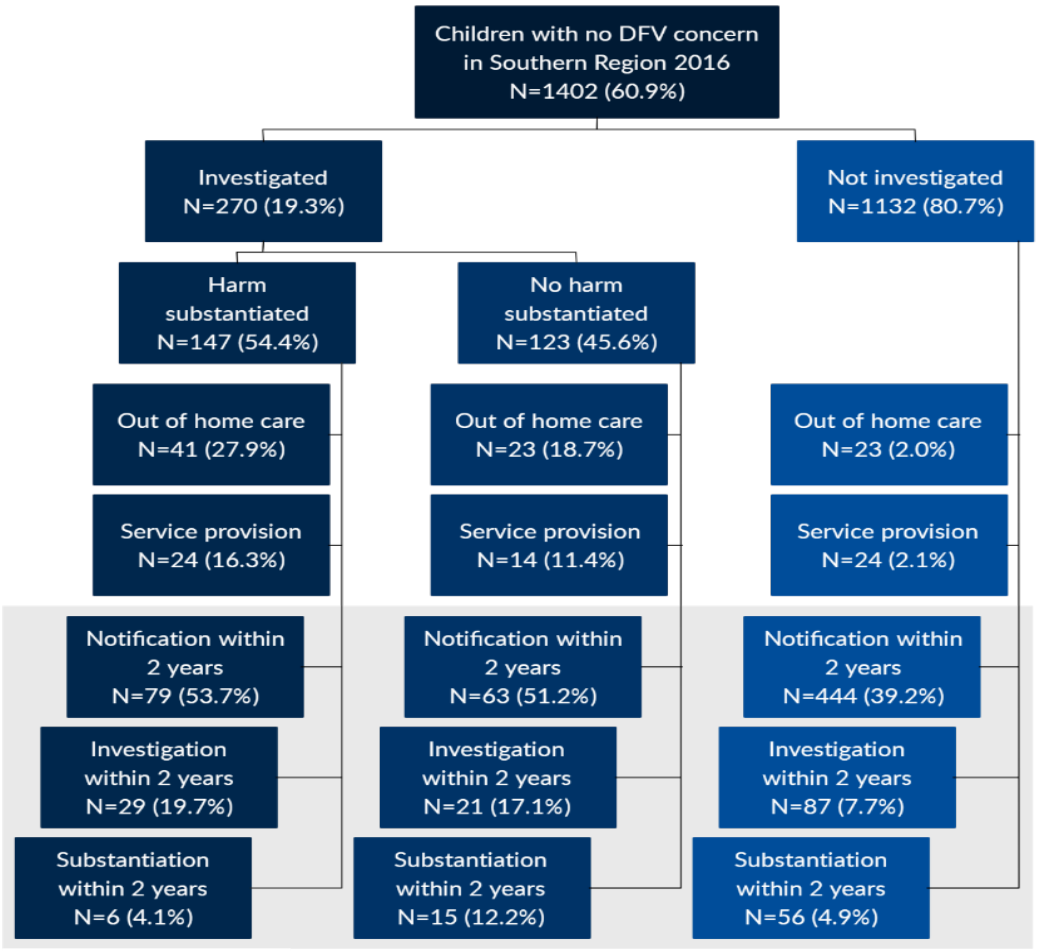


3.2.3 Pathways for children without DFV concerns in 2016

Figure 3 shows the deepest contact with DCP for the children that were screened in and there was no record that they were living in a context of DFV in 2016 and for the 2-year follow-up period. Results show that of the 1402 children, 19% (270) of the children were involved in an investigation, comparable to that for children with a DFV concern. Of the 270 children involved in an investigation, 54% (147) had a substantiation in 2016. The percentage of children who were placed in OOHC in this cohort ranged from 28% to 2% for the children who had a substantiation and those not investigated, respectively. Overall, 6% of children with only non-DFV concerns commenced an OOHC placement.

Similarly, the percentage of children who were referred to a service ranged from 16% to 2% for those same groups of children. Analysis indicates that there was a higher percentage of children who were investigated had a placement in OOHC and were referred to a service, compared to those children who were not the subject of an investigation. The same can be said for notifications, investigations, and substantiations in a 2-year follow-up period. Overall, 42% of children reported for only non-DFV concerns had another notification in the 2-year follow-up period. This percentage is lower than that for children experiencing DFV (50%).

Figure 3. Child protection pathways for children who did not experienced DFV concerns 2016 -2018



3.3 Modelling associations between having notifications for DFV concerns and CP outcomes

Tables showing all model results are presented in Section 3.3.2.

Children with at least 1 notification related to DFV in 2016 were 16% less likely to have an investigation that year, compared to children with no DFV related notifications that year (Table 2, Section 3.3.2). For children who only had 1 notification in 2016, they were 83% less likely to be investigated if that notification was related to DFV. This suggests that children who experience DFV are less likely to receive statutory intervention at their first point of contact.

Looking at only the children who were the subject of an investigation, those with a DFV concern were 48% more likely to be the subject of a substantiation (Table 3, Section 3.3.2). If you look at just those children with 1 notification, they were 276% more likely to have harm substantiated if that notification was related to DFV. This suggests that although children with a DFV concern were less likely to be the subjects of investigation, those who were investigated were more likely to go on to have a substantiation.

Children who had a DFV notification in 2016 were no more likely to have a placement than children with only non-DFV concerns (Table 4, Section 3.3.2). However, they were, 33% more likely to be referred to a service (Table 5, Section 3.3.2).

Children with a DFV-related notification in 2016 were 14% more likely to have a notification in 2017-2018 (Table 6, Section 3.3.2). Looking at just the children who had 1 notification in 2016, those with a DFV concern were 5% more likely to have a notification in the follow-up period. Just looking at the children who had a renotification, those with a DFV concern in 2016 were 4% less likely to have an investigation (Table 7, Section 3.3.2). Children who were investigated in 2017-2018 and were allegedly living in a context of DFV in 2016 were 45% more likely to have a substantiation (Table 8, Section 3.3.2) in the follow-up period. Children who had experienced domestic and family violence and assessed to have experienced harm were slightly more likely to continue having contact with DCP, but this association did not remain statistically significant after controlling for other factors.

Key message

Compared to children with a non-DFV notification, children who experienced domestic and family violence in2016 were slightly less likely to have been the subject of statutory intervention. However, among those children who received a statutory response, children who experienced DFV- were 45% more likely to have experienced harm (substantiated investigation).

Regression models assessing associations

Table 2. Associations between having a DFV notification and receiving an **investigation** in 2016, adjusted for demographic and CP history *

	1 notification 2016 (N=1,301)		**≥ 2 notifications 2016** (N=807)		**All children** (N=2,108)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age (<1)	2.25	[1.36, 3.75]	1.49	[1.07, 2.08]	2.26	[1.72, 2.97]
Sex (Female)	0.92	[0.72, 1.18]	1.31	[0.93, 1.38]	1.04	[0.89, 1.21]
Aboriginal and/or Torres Strait Islander peoples	0.89	[0.63, 1.25]	1.15	[0.91, 1.44]	1.24	[1.03, 1.50]
Notification 2015	1.29	[0.88, 1.90]	1.06	[0.83, 1.34]	1.73	[1.43, 2.10]
Investigation 2015	2.70	[1.47, 4.97]	2.14	[1.59, 2.89]	2.42	[1.88, 3.11]
OOHC placement 2015	4.46	[2.65, 7.50]	1.23	[0.86, 1.76]	1.90	[1.41, 2.55]
Service provision 2015	0.52	[0.23, 1.18]	0.82	[0.47, 1.45]	0.76	[0.48, 1.21]
Report on Unborn 2015	5.66	[2.79, 11.49]	1.70	[1.05, 2.73]	1.80	[1.23, 2.62]
DFV-related notification 2016	0.17	[0.10, 0.28]	0.87	[0.71, 1.07]	0.84	[0.71, 1.00]

PR = prevalence ratio, CI = confidence interval.

*Variables representing prior contact with Child protection are included in the model to control for variation in existing risk or known risk that may explain CP outcomes (proxy for risk profile)

Table 3. Associations between having a DFV notification and receiving and being the subject of a substantiation in 2016, adjusted for demographic and CP history

	1 notification 2016 (N=94)		**≥ 2 notifications 2016** (N=301)		**All children** (N=395)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age (<1)	0.37	[0.09, 1.44]	0.94	[0.64, 1.39]	0.88	[0.62, 1.25]
Sex (Female)	1.17	[0.79, 1.73]	1.11	[0.88, 1.41]	1.12	[0.91, 1.37
Aboriginal and/or Torres Strait Islander peoples	0.88	[0.46, 1.71]	1.01	[0.78, 1.32]	0.97	[0.76, 1.23]
Notification 2015	1.51	[0.92, 2.48]	0.99	[0.75, 1.31]	1.04	[0.82, 1.33]
Investigation 2015	0.13	[0.03, 0.56]	0.85	[0.59, 1.23]	0.72	[0.51, 1.01]
OOHC placement 2015	0.24	[0.08, 0.74]	0.46	[0.26, 0.79]	0.44	[0.27, 0.71]
Service provision 2015	0.42	[0.09, 2.09]	0.73	[0.30, 1.82]	0.78	[0.36, 1.70]
Report on Unborn 2015	1.68	[0.35, 8.13]	0.99	[0.58, 1.71]	1.16	[0.74, 1.84]
DFV-related notification 2016	3.76	[1.46, 9.66]	1.54	[1.21, 1.96]	1.48	[1.19, 1.83]

Model Includes only children investigated in 2016, PR = prevalence ratio, CI = confidence interval.

Table 4. Associations between having a DFV notification and experiencing an out of home care placement 2016, adjusted for demographic and CP history *

	All children (N=2,108)	
	PR	**PR 95% CI**
Age (<1)	2.16	[1.64, 2.85]
Sex (Female)	1.03	[0.87, 1.21]
Aboriginal and/or Torres Strait Islander peoples	2.11	[1.77, 2.50]
Notification 2015	1.02	[0.84, 1.26]
Investigation 2015	1.79	[1.41, 2.28]
OOHC placement 2015	7.17	[5.80, 8.87]
Service provision 2015	1.14	[0.86, 1.52]
Report on Unborn 2015	4.99	[3.61, 6.91]
Notification 2016	7.75	[5.95, 10.08]
DFV-related notification 2016	1.01	[0.85, 1.21]

PR = prevalence ratio, CI = confidence interval.

Table 5. Associations between having a DFV notification and referred to a service in 2016, adjusted for demographic and CP history *

	All children (N=2,108)	
	PR	**PR 95% CI**
Age (reference= <1 year)	1.55	[1.06, 2.25]
Sex (reference = Female)	1.06	[0.88, 1.27]
Aboriginal and/or Torres Strait Islander peoples	1.31	[1.07, 1.61]
Notification 2015	1.27	[1.01, 1.59]
Investigation 2015	1.80	[1.40, 2.33]
OOHC placement 2015	8.47	[6.75, 10.62]
Service provision 2015	1.50	[1.12, 2.01]
Report on Unborn 2015	3.06	[1.96, 4.76]
Notification 2016	4.23	[3.29, 5.43]
DFV-related notification 2016	1.33	[1.10, 1.62]

PR = prevalence ratio, CI = confidence interval.

Table 6. Associations between having a DFV notification and being the subject of re-notification in 2017-2018 adjusted for demographic and CP history *

	1 notification 2016 (N=1,301)		≥ 2 notifications 2016 (N=807)		All children (N=2,108)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age (in 2016, reference = < 1 year)						
1 – 15 years	1.38	[0.83, 2.31]	1.25	[0.75, 2.08]	1.35	[0.94, 1.92]
≥ 16 years	0.67	[0.35, 1.28]	0.88	[0.48, 1.63]	0.81	[0.52, 1.25]
Sex (reference = Female)	0.97	[0.81, 1.18]	1.09	[0.91, 1.30]	1.02	[0.89, 1.16]
Aboriginal and/or Torres Strait Islander peoples	1.39	[1.09, 1.76]	1.11	[0.90, 1.37]	1.27	[1.08, 1.48]
Investigation 2016	1.10	[0.76, 1.61]	1.10	[0.89, 1.35]	1.32	[1.11, 1.58]
OOHC placement 2016	0.92	[0.37, 2.27]	0.90	[0.65, 1.25]	0.92	[0.67, 1.26]
Service provision 2016	1.73	[0.84, 3.56]	1.03	[0.72, 1.49]	1.17	[0.84, 1.63]
Report on Unborn 2016	-	-	1.29	[0.67, 2.48]	1.68	[0.98, 2.89]
DFV-related notification 2016	1.05	[0.85, 1.29]	1.07	[0.89, 1.29]	1.14	[0.99, 1.31]

PR = prevalence ratio, CI = confidence interval.

Table 7. Associations between having a DFV notification and investigated and being the subject of another investigation for two year follow up period (2017-2018, adjusted for demographic and CP history *

	All children (N=939)	
	PR	**PR 95% CI**
Age (<1)	0.98	[0.46, 2.10]
Sex (Female)	0.84	[0.64, 1.10]
Aboriginal and/or Torres Strait Islander peoples	0.71	[0.50, 1.03]
Investigation 2016	1.75	[1.27, 2.40]
OOHC placement 2016	0.69	[0.40, 1.19]
Service provision 2016	1.39	[0.81, 2.39]
Report on Unborn 2016	2.01	[0.79, 5.16]
Notification 2016	1.52	[1.10, 2.10]
DFV-related notification 2016	0.96	[0.72, 1.28]

Includes only children that had a renotification, PR = prevalence ratio, CI = confidence interval.

Table 8. Associations between having a DFV notification and having a substantiation in two year follow up period (2017-2018), adjusted for demographic and CP history *

	All children (N=219)	
	PR	**PR 95% CI**
Age (<1)	1.10	[0.43, 2.82]
Sex (Female)	0.87	[0.61, 1.25]
Aboriginal and/or Torres Strait Islander peoples	0.83	[0.50, 1.39]
Investigation 2016	0.73	[0.46, 1.15]
OOHC placement 2016	0.75	[0.33, 1.72]
Service provision 2016	0.97	[0.46, 2.02]
Report on Unborn 2016	1.04	[0.32, 3.45]
Notification 2016	0.84	[0.54, 1.29]
DFV-related notification 2016	1.45	[0.97, 2.15]

Includes only children investigated in 2017-2018, PR = prevalence ration, CI = confidence interval.

3.4 Experiences of Aboriginal and Torres Strait Islander children

In the total population of children in 2016, 17% (357) children were identified as Aboriginal or Torres Strait Islander and (75%) 1,586 were non-Indigenous. Of the 357 Aboriginal and Torres Strait Islander children, 24% (85) had an investigation. This percentage is higher than that for the non-Indigenous children (18%, 285)). Of all the children who were the subject of investigations, 22% were Aboriginal and Torres Strait Islander and 72% were non-Indigenous. The analysis of the Southern Metropolitan cohort is consistent with the national trend where there is an overrepresentation of Aboriginal and Torres Strait Islander children in child protection (AIHW, 2020)

Of the 357 Aboriginal and Torres Strait Islander children who were the subject of an investigation, 52 (15%) had a substantiation. This percentage is higher than that for non-Indigenous children (176 children 11%). Across South Australia in 2016-17, 1526 children had a substantiation. 469 (31%) of these children are Aboriginal and Torres Strait Islander and 947 are non-Indigenous (62%). The percentage of children with a substantiation that are Aboriginal and Torres Strait Islander across South Australia is 6.9 times that in the South Australian population (4.5%). This over-representation across the state is consistent with the national data (6.8 times), but greater than that in the Southern Region of Adelaide as seen in our data.

Of the 357 Aboriginal and Torres Strait Islander children, 52 were placed in out of home care (15%). This percentage is three times higher than that for non-Indigenous children (86 children, 5%). When looking at the children placed in out of home care, 36% were Aboriginal and Torres Strait Islander peoples and 59% were non-Indigenous. The percentage of Aboriginal and Torres Strait Islander children placed in care is 8 times the percentage of children across South Australia that are Indigenous (4.5%). Across South Australia in 2016-17, 724 children were admitted to OOHC. Of those children 250 were Aboriginal and Torres Strait Islander (35%) and 413 were non-Indigenous (57%). The percentage of children commencing OOHC who are Aboriginal and Torres Strait Islander across South Australia is 7.8 times that in the South Australian population (4.5%). This over-representation is consistent with our data in the Southern Region of Adelaide, but greater than that for the national data (6.4 times over-representation).

According to the tables in Section 3.3.2, when controlling for demographic and risk profile variables, Aboriginal and Torres Strait Islander children were 24% more likely to be investigated, and as likely to have a substantiation in 2016, compared to non-Indigenous children. Further, they were 111% more likely to have an OOHC placement in 2016, and 31% more likely to be provided a service. During the 2-year follow-up period, Aboriginal and

Torres Strait Islander children were 27% more likely to be renotified, but 29% less likely to have an investigation and 17% less likely to have a substantiation.

3.4.1 Effect of DFV on outcomes for Aboriginal and Torres Strait Islander children

As presented in the demographics section, 21% of children with a DFV concern were from Aboriginal and Torres Strait Islander backgrounds, while 15% of children with only non-DFV concerns were Aboriginal and Torres Strait Islander peoples. The analysis indicates that Aboriginal and Torres Strait Islander children were 29% more likely to have a DFV concern in 2016 (Table 9, Section 3.4.1). However, for children with one notification in 2016, Aboriginal and Torres Strait Islander children were as likely as non-Indigenous children for that notification to be DFV-related. It is possible that Aboriginal children are more likely to have DFV-related notification because they are more likely to receive multiple notifications during the year.

The percentage of children either having experienced DFV or not and whether they were Aboriginal and Torres Strait Islander peoples or not for each outcome was graphed. Figure 4A in Section 3.4.3 demonstrates that 25% of the children who were Aboriginal and Torres Strait Islander and had a DFV notification in 2016 were investigated that year. In addition, approximately 15% of non-Indigenous children with a DFV notification were investigated. A similar pattern can be seen for the children with only non-DFV concerns. This shows that Aboriginal and Torres Strait Islander children were more likely to be investigated whether they were reported for DFV or not.

As noted previously, Aboriginal and Torres Strait Islander children were as likely to have a substantiation in 2016 as non-Indigenous children. This appears to only be the case for children with a DFV concern; a comparable percentage of Aboriginal and Torres Strait Islander children with a DFV concern had a substantiation, compared to the non-Indigenous children with a DFV concern (Figure 4B, Section 3.4.3). In contrast, a lower percentage of Aboriginal and Torres Strait Islander children with only non-DFV concerns had a substantiation compared to non-Indigenous children with non-DFV concerns.

A contrasting pattern was seen for referrals made to services by DCP in 2016 (Figure 4D, Section 3.4.3). Aboriginal and Torres Strait Islander children were more likely than non-Indigenous children to be referred to a service in 2016. However, this appeared to only be the case for children with a DFV concern. A comparable percentage of Aboriginal and Torres Strait islander children with only non-DFV concerns were referred to a a service to those that were non-Indigenous.

Overall, Aboriginal and Torres Strait Islander children were less likely than non-Indigenous children to have an investigation or substantiation in the two year follow up period (2017-2018) (Figure 5B and C, Section 3.4.3). The analysis indicates that a smaller percentage of Aboriginal and Torres Strait Islander children with a DFV concern in 2016 had an investigation and/or substantiation in the two-year follow-up period compared to the non-Indigenous children with a DFV concern. In contrast, a comparable percentage of Aboriginal and Torres Strait Islander and non-Indigenous children with non-DFV concerns had an investigation and substantiation.

There were no associations between being an Aboriginal and Torres Strait Islander person and having a DFV concern for being investigated in 2016 (as explained above), placed in OOHC in 2016 (Figure 4C, Section 3.4.3) or renotified in 2017-2018 (Figure 5A, Section 3.4.3). As above, Aboriginal and Torres Strait Islander children were more likely to have an investigation and be placed in OOHC in 2016, but this was the case for both cohorts of children with and without DV concerns. The same was the case for being renotified in 2017-2018.

Key message

Aboriginal and Torres Strait Islander children were more likely to be the subjects of an investigation than non-Indigenous children, regardless of whether they were reported for DFV concerns.

It was noted that Aboriginal children who were reported for DFV concerns were less likely than non-Aboriginal children to have continued contact with DCP. Among those Aboriginal and Torres Strait Islander children who were the subjects of an investigation were less likely to have experienced harm (substantiation) after

3.4.2 Regression models assessing associations with having a DFV notification

Table 9. Associations between having a DFV notification in 2016, adjusted for demographic and CP history *

	1 notification 2016 (N=1,301)		≥ 2 notifications 2016 (N=807)		All children (N=2,180)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age (<1)	1.38	[0.91, 2.08]	1.00	[0.71, 1.42]	1.21	[0.93, 1.59]
Sex (Female)	0.90	[0.75, 1.08]	0.99	[0.82, 1.19]	0.93	[0.81, 1.06]
Aboriginal and/or Torres Strait Islander peoples	1.03	[0.80, 1.33]	1.38	[1.13, 1.69]	1.29	[1.10, 1.50]
Notification 2015	1.05	[0.78, 1.41]	1.25	[1.03, 1.53]	1.35	[1.15, 1.58]
Investigation 2015	0.77	[0.32, 1.85]	0.91	[0.64, 1.28]	0.95	[0.69, 1.31]
OOHC placement 2015	0.53	[0.18, 1.56]	0.66	[0.41, 1.05]	0.70	[0.45, 1.08]
Service provision 2015	0.53	[0.08, 3.47]	0.35	[0.13, 0.95]	0.37	[0.16, 0.90]
Report on Unborn 2015	1.00	[0.39, 2.58]	1.31	[0.76, 2.26]	1.12	[0.69, 1.82]

PR = prevalence ratio, CI = confidence interval.

3.4.3 DFV notification and Aboriginal and/or Torres Strait Islander status by child protection outcomes

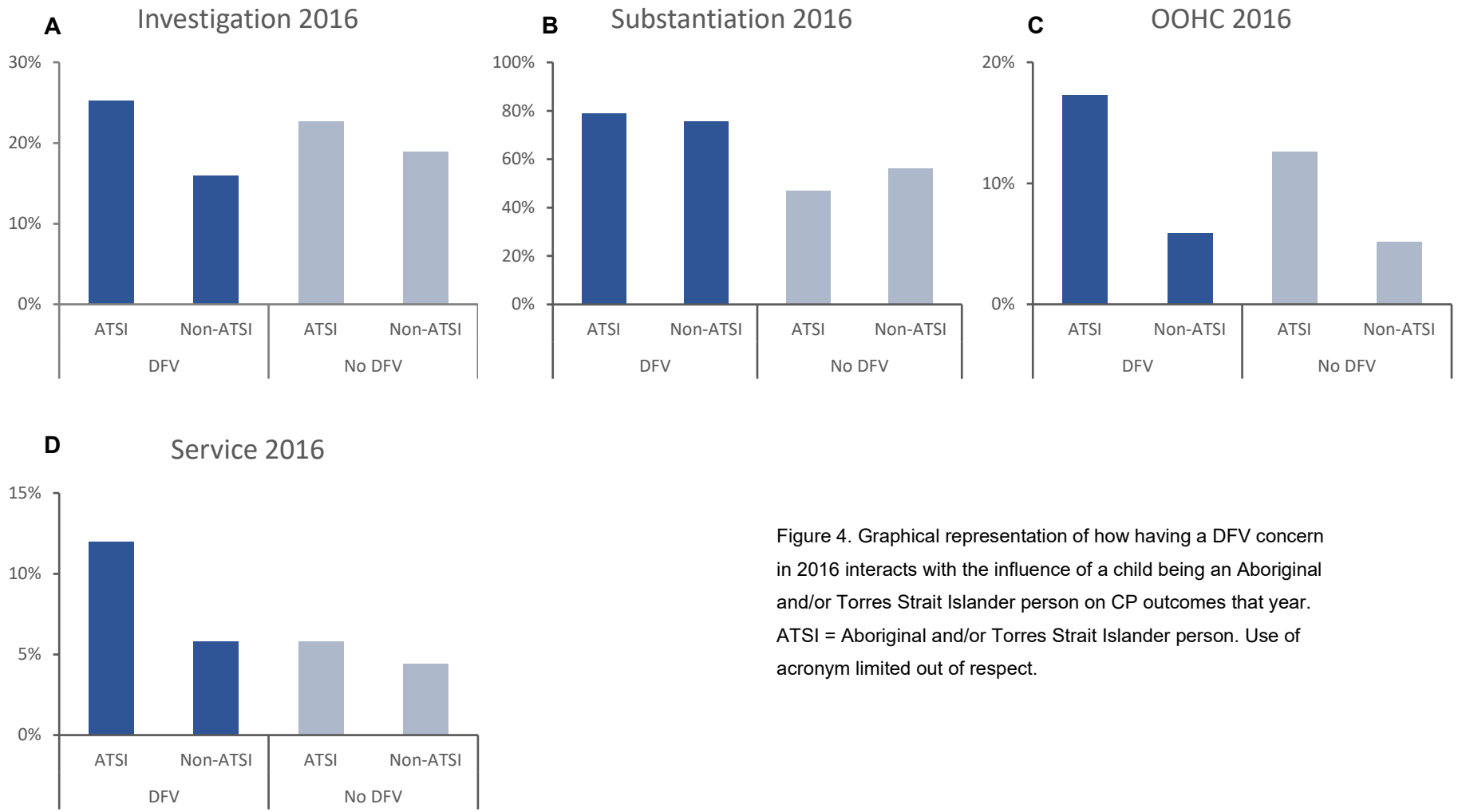


Figure 4. Graphical representation of how having a DFV concern in 2016 interacts with the influence of a child being an Aboriginal and/or Torres Strait Islander person on CP outcomes that year. ATSI = Aboriginal and/or Torres Strait Islander person. Use of acronym limited out of respect.

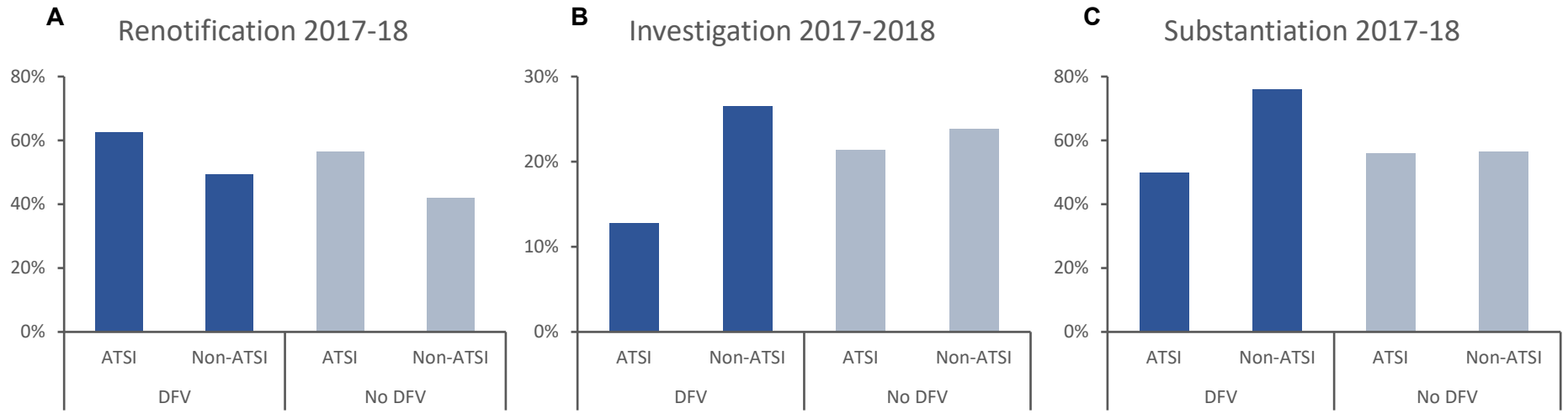


Figure 5. Associations between having a DFV-related concern in 2016, being an Aboriginal and/or Torres Strait Islander person and child protection outcomes in the 2-year follow-up period. ATSI = Aboriginal and/or Torres Strait Islander person. Use of acronym limited out of respect.

3.5 Services and OOHC placements for children with DFV concerns

3.5.1 OOHC placements

Across the period we examined (July 2015 – December 2018), 2,309 OOHC placements either began or ended for children in the Southern Metropolitan Region of Adelaide. Of those, 344 placements began in 2016. The most common types of care were foster care, residential care, and kinship care. A comparable percentage of children with either DFV concerns or non-DFV concerns only had 0, 1 or more than 2 placements, supporting the finding above that children with DFV were as likely to have a placement. The percentage of children that were placed in each type of OOHC also did not appear to differ considerably between the children with and without DFV concerns.

Table 10. OOHC placement number and type in 2016 by experience of DFV.

	DFV concerns (N=706)		**No DFV concerns** (N=1,402)		**All children** (N=2,108)	
	N	**%**	**N**	**%**	**N**	**%**
OOHC placements						
0	647	91.6	1315	93.8	1990	93.1
1	31	4.4	46	3.3	77	3.7
≥2	28	4.0	41	2.9	69	3.2
Foster care	24	3.4	33	2.4	57	2.7
Residential care	11	1.6	34	2.4	45	2.1
Commercial property	19	2.7	18	1.3	37	1.8
Kinship care	27	3.8	26	1.9	53	2.5
Specific child only care	5	0.7	6	0.4	11	0.5
Reunified	10	1.4	18	1.3	28	1.3

Key message

The types of OOHC placements that children were placed in did not differ between those who experienced DFV and those who did not.

3.5.23 Services

Across the period we examined (July 2015 – December 2018), 1834 services were provided to children or referrals were made for children and/or their families in the Southern Metropolitan Region of Adelaide. Of those, only 12 were provided for DFV-related needs: 4 involved financial assistance, 7 involved other community services and 1 involved women's domestic violence counselling. In 2016, 182 services were provided. The most common types of services were psychological services, kinship care and those involving drug & alcohol assistance. There were no DFV-specific services.

Table 11. Service number and type in 2016 by DFV concerns.

	DFV concerns (N=706)		**No DFV concerns** (N=1,402)		**All children** (N=2,108)	
	N	**%**	**N**	**%**	**N**	**%**
Services count						
0	660	93.5	1340	95.6	2000	94.9
1	35	5.0	42	3.0	77	3.7
≥2	11	1.5	20	1.4	31	1.4
Psychological service	15	2.1	25	1.8	40	1.9
Kinship care	21	3.0	6	0.4	27	1.3
Drug & Alcohol service	14	2.0	10	0.7	24	1.1
School retention	3	0.4	9	0.6	12	0.6
Financial support	0	0.0	5	0.4	5	0.2
Intensive placement prevention or support	3	0.4	12	0.9	15	0.7
Other	2	0.3	13	0.9	15	0.7

Key message

The types of services that were provided to children did not differ between those who experienced DFV and those that did not.

Provision of DFV-specific services were not recorded for children in the Southern Region in 2016.

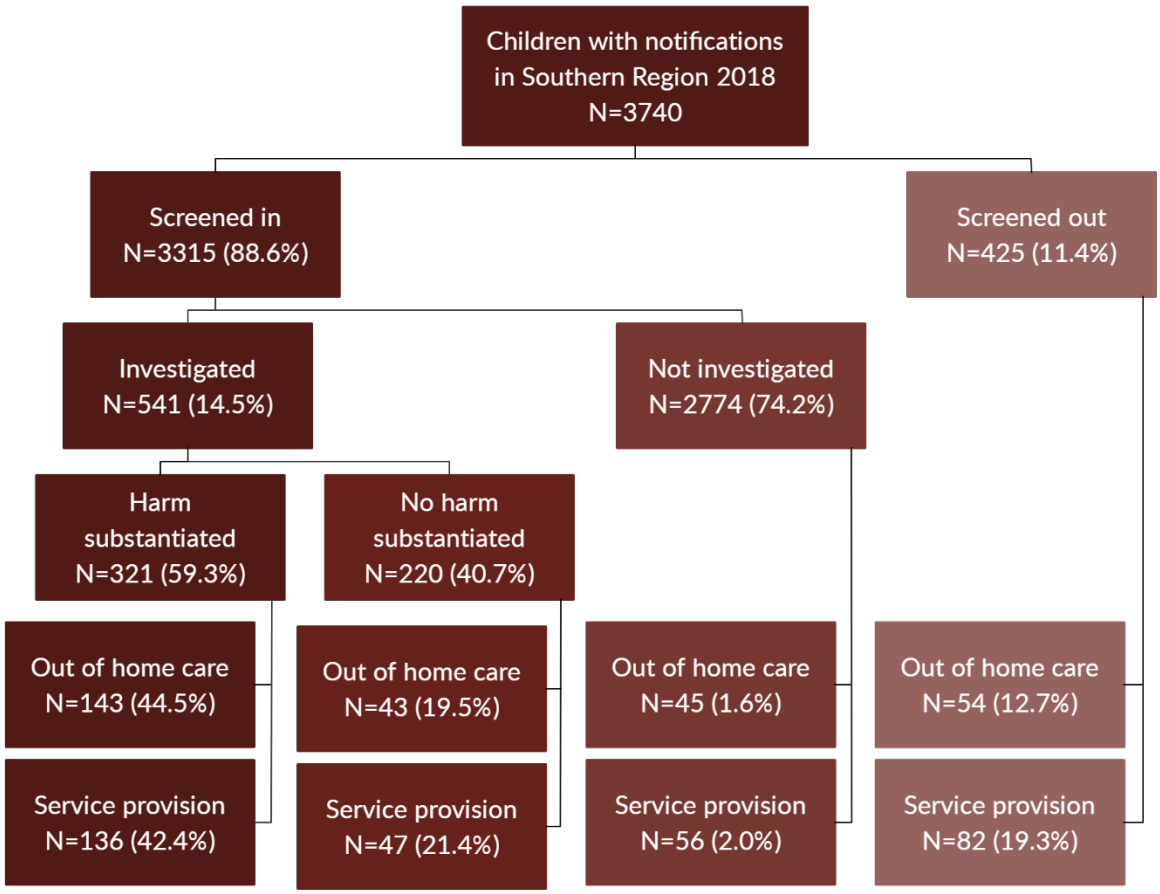
3.2 Comparison of pathway diagrams between 2016 and 2018

There were 6,987 notifications to DCP in the Southern Metropolitan Region of Adelaide in 2018 compared to 4000 notifications in 2016. The 6,987 notifications related to 3,740 children compared to 2,301 children in 2016.

3.2.1 Pathways for all children in 2018

Figure 6 shows the deepest contact each child had with DCP in 2018. Of the children screened in, 15% were investigated in 2018, compared to 19% in 2016. Of the children investigated, 59% had a substantiated notification in 2018, which is comparable to that in 2016 (61%). The percentage of children who experienced an out of home care placement ranged from 45% to 2% for the children that had a substantiation and those not investigated, respectively. This is higher than that in 2016 (ranged from 35% to 1%). Similarly, the percentage of children who were provided a service in 2016 ranged from 42% to 2%, again higher than that in 2016 (ranged from 24% to 1%).

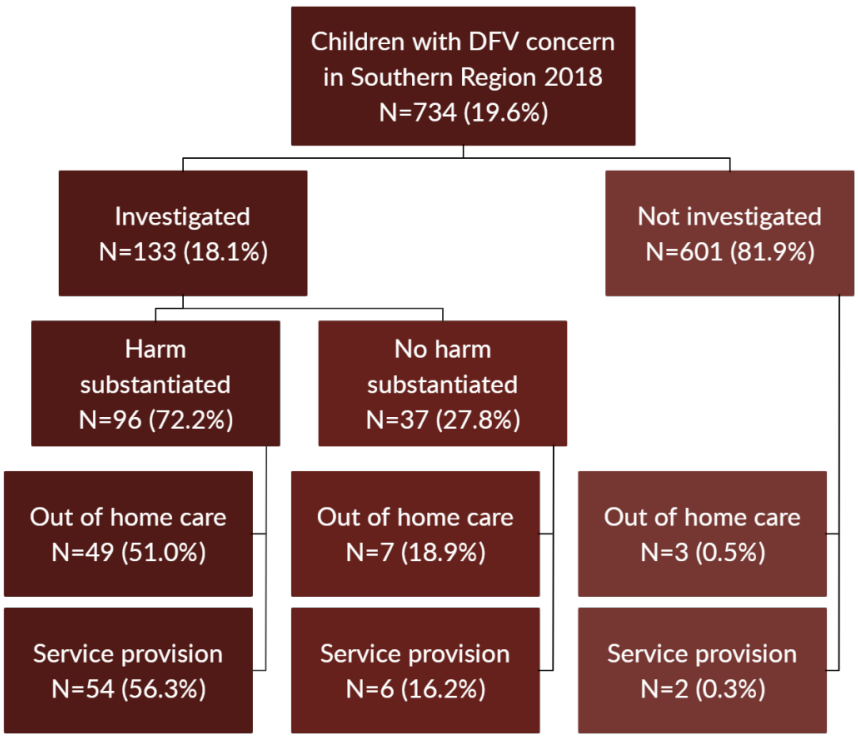
Figure 6. Child protection outcomes for children notified in 2018



3.2.2 Pathways for children with DFV concerns in 2018

Of the 6,987 notifications in 2018, 14% (975) had an alleged ground associated with DFV. The number of notifications where DFV concerns were identified in 2018 was comparable to that in 2016 (939 DFV notifications), but the percentage is lower (14% compared to 24%) given there was a disproportionate increase in the number of notifications without DFV concerns. DFV-related notifications related to 734 children. Again, this number is comparable to that in 2016 (706 children) but the percentage is lower (20% compared to 31%) given the increase in the number of children reported for only non-DFV concerns. Figure 7 shows the deepest contact with DCP for children with a DFV concern in 2018. The pathway shows that 18% of children with a DFV concern in 2018 were investigated and that 72% of those children had a substantiation. The percentage investigated was comparable to what was seen in 2016, but the percentage of children with a substantiation was slightly lower (18% investigated, 76% of those had a substantiation). The percentage of children who went in to OOHC ranged from 51% to 1% for the children that had a substantiation and those not investigated, respectively. This was higher than that for children with a DFV concern in 2016 (ranged from 48% to 0%). The percentage of children with a DFV concern in 2018 who were referred to a service ranged from 56% to 16% for those same groups. This is larger than that recorded for the children with a DFV concern in 2016 (ranged from 36% to 0%).

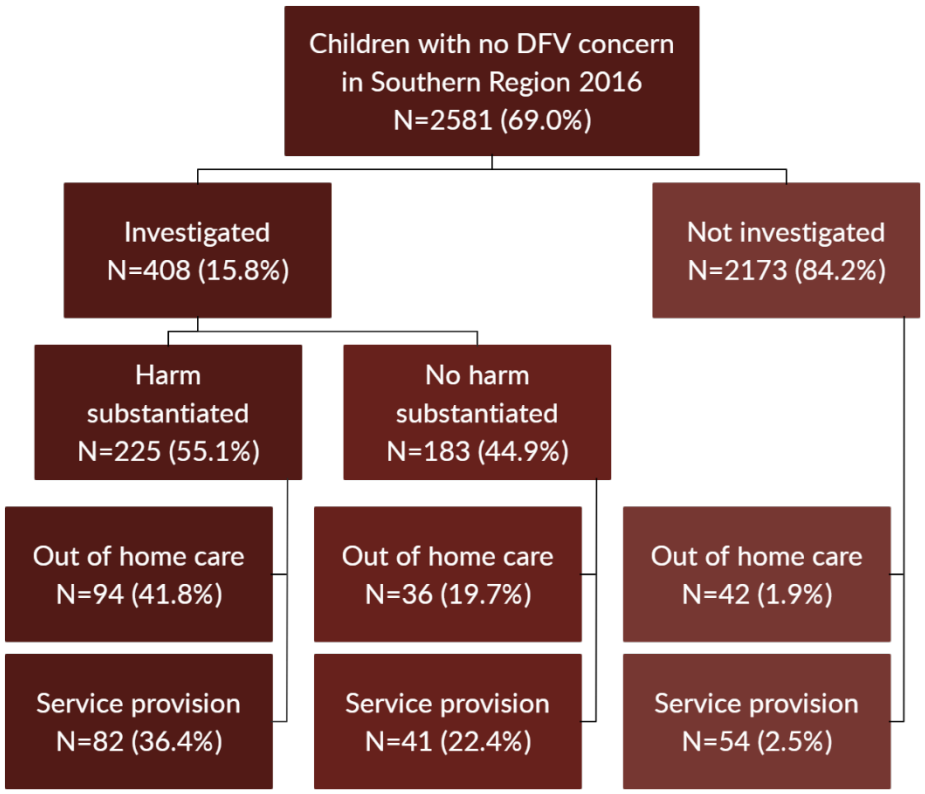
Figure 7. Child protection outcomes for children with a DFV concern in 2018



3.2.3 Pathways for all children without DFV concerns in 2016

Figure 8 shows the deepest contact with DCP for the children who were screened in but had no DFV concerns in 2018. The pathway shows that 16% of children were investigated and that 55% of those children had a substantiation. The percentage investigated is lower than that in 2016 (19%), but that for those with a substantiation in 2016 is comparable (54%). The percentage of children who were provided OOHC ranged from 42% to 2% for those with a substantiation and those not investigated, respectively. This is higher than that for the children with only non-DFV concerns in 2016 (ranged from 28% to 2%). The percentage of children who were provided a service ranged from 36% to 3%. Again, this is higher than that for the children in 2016 (ranged from 16% to 2%).

Figure 8. Child protection outcomes for children with non-DFV concerns in 2018



3.3 Comparison of associations between DFV-related notifications and CP outcomes for 2016 and 2018

The statistical output for all models is presented in Section 3.7.2.

Analysis demonstrates that those children reported for a DFV concern in 2018 were 10% more likely to have an investigation (Table 12, Section 3.7.2). However, children with just one notification were 44% less likely to have an investigation if that notification was related to DFV. Further, children with 2 or more notifications, with at least one related to DFV, were 8% less likely to have an investigation. Furthermore, the number of notifications in 2018 was included as a predictor variable and this model was run on all children. This showed that children with a DFV concern were 14% less likely to have an investigation (Table 13, Section 3.7.2). This is consistent with what was found for 2016.

Of the children investigated and those with a DFV concern were 29% more likely to have a substantiation (Table 14, Section 3.7.2). Again, this is consistent with what was found in 2016. Although, it should be noted, the model could not be stratified by number of notifications in 2018, as was done in 2016.

Children with a DFV related notification in 2018 were 29% more likely to have an OOHC placement, compared to children with only non-DFV concerns (Table 15, Section 3.7.2). Consistent with this, the children with only 1 notification, those who had a DFV concern were 23% more likely to be placed in OOHC. This model was stratified by number of notifications in 2018, which could not be done for the data in 2016. To compare 2016 and 2018, notification number in 2018 was included as a predictor variable. In this case, the likelihood of being placed in OOHC was the same for children with and without DFV concerns (Table 16, Section 3.7.2). This is consistent with 2016. It is unclear whether the prevalence ratio for DFV-related notifications may have predicted OOHC in 2016 had the model been able to be stratified by notification number.

The children with a DFV concern were also 42% more likely to have a service in 2018 (Table 17, Section 3.7.2). However, when looking at just those with 1 notification, they were 26% less likely to have a service, while those with 2 or more notifications were 12% more likely to have a service. As with OOHC in 2016, the model for services in 2016 could not be stratified by number of notifications. To compare the two years, notification number in 2018 was included as a predicator variable. In this case, children with a DFV concern in 2018 were 10% more likely to be given a service. This is consistent with 2016. Given it was not stratified, it is unclear whether children with a 1 notification that was related to DFV in 2016 were also less likely to be given a service, as is the case in 2018.

Key message

After controlling for other explanatory variables, children with a DFV-related notification in 2018 were less likely to have an investigation, but of those children who received a statutory response were more likely to have experienced harm (substantiation). This result was consistent with the findings for 2016.

Furthermore, children who had a DFV concern in 2018 were as likely to be placed in OOHC, but more likely to be referred to a service.

3.3.1 Regression output tables for predicting outcomes

Table 12. Associations between having a DFV notification in 2018 and receiving an investigation in 2018.

	1 notification 2018 (N=2,008)		≥ 2 notifications 2018 (N=1,307)		All children (N=3,315)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age						
<1	-	-	-	-	-	-
1	1.83	[0.63, 5.34]	0.44	[0.13, 1.43]	1.49	[0.63, 3.53]
≥2	0.59	[0.21, 1.64]	0.25	[0.08, 0.80]	0.58	[0.25, 1.34]
Sex (Female)	1.03	[0.82, 1.29]	0.81	[0.68, 0.95]	0.86	[0.75, 0.98]
Aboriginal and/or Torres Strait Islander peoples	0.61	[0.41, 0.90]	1.02	[0.85, 1.22]	1.28	[1.10, 1.49]
Notification 2016-17	0.69	[0.49, 0.96]	1.06	[0.87, 1.28]	1.42	[1.21, 1.66]
Investigation 2016-17	2.89	[1.75, 4.77]	1.87	[1.47, 2.38]	2.37	[1.92, 2.91]
OOHC placement 2016-17	1.51	[0.54, 4.21]	0.96	[0.63, 1.46]	1.07	[0.73, 1.58]
Service provision 2016-17	2.09	[0.77, 5.69]	1.26	[0.83, 1.90]	1.57	[1.07, 2.30]
Report on Unborn 2016-17	3.79	[2.11, 6.83]	1.30	[0.88, 1.92]	1.27	[0.92, 1.74]
DFV-related notification 2018	0.56	[0.38, 0.81]	0.91	[0.76, 1.09}	1.10	[0.95, 1.28]

PR = prevalence ratio, CI = confidence interval.

Table 13. Associations between having a DFV notification and having an **investigation** in 2018.

	All children (N=3,315)	
	PR	**PR 95% CI**
Age		
<1	-	-
1	0.67	[0.31, 1.47]
≥2	0.36	[0.17, 0.77]
Sex (Female)	0.84	[0.74, 0.94]
Aboriginal and/or Torres Strait Islander peoples	0.99	[0.86, 1.13]
Notification 2016-170.99	1.01	[0.87, 1.16]
Investigation 2016-17	1.98	[1.65, 2.38]
OOHC placement 2016-17	0.98	[0.71, 1.35]
Service provision 2016-17	1.33	[0.97, 1.83]
Report on Unborn 2016-17	1.44	[1.08, 1.92]
Notifications 2018	6.57	[5.57, 7.75]
DFV-related notification 2018	0.86	[0.75, 0.99]

PR = prevalence ratio, CI = confidence interval.

Table 14. Associations between having a DFV notification and a substantiation in 2018.

	All children (N=541)	
	PR	**PR 95% CI**
Age		
<1	-	-
1	1.24	[0.41, 3.75]
≥2	0.78	[0.26, 2.33]
Sex (Female)	1.16	[0.97, 1.39]
Aboriginal and/or Torres Strait Islander peoples	0.94	[0.76, 1.16]
Notification 2016-17	1.23	[0.99, 1.53]
Investigation 2016-17	1.04	[0.80, 1.36]
OOHC placement 2016-17	0.72	[0.44, 1.18]
Service provision 2016-17	0.84	[0.53, 1.34]
Report on Unborn 2016-17	0.78	[0.51, 1.19]
Notifications 2018	1.37	[1.03, 1.82]
DFV-related notification 2018	1.29	[1.06, 1.57]

PR = prevalence ratio, CI = confidence interval.

Table 15. Associations between having a DFV notification and an **OOHC placement** in 2018.

	1 notification 2018 (N=2,008)		**≥ 2 notifications 2018** (N=1,307)		**All children** (N=3,315)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age						
<1	-	-	-	-	-	-
1	0.94	[4.8, 1.85]	0.57	[0.15, 2.19]	1.34	[0.63, 2.88]
≥2	0.11	[0.06, 0.22]	0.17	[0.05, 0.65]	0.26	[0.12, 0.56]
Sex (Female)	0.87	[0.68, 1.12]	0.90	[0.74, 1.10]	0.94	[0.81, 1.08]
Aboriginal and/or Torres Strait Islander peoples	0.83	[0.59, 1.18]	1.20	[0.98, 1.48]	1.47	[1.25, 1.72]
Notification 2016-17	0.78	[0.54, 1.12]	0.86	[0.67, 1.12]	1.24	[1.03, 1.51]
Investigation 2016-17	1.37	[0.83, 2.26]	2.43	[1.83, 3.21]	2.56	[2.05, 3.20]
OOHC placement 2016-17	1.11	[0.56, 2.18]	2.69	[1.82, 3.99]	3.22	[2.29, 4.53]
Service provision 2016-17	29.74	[15.85, 55.80]	2.17	[1.48, 3.18]	2.73	[1.96, 3.79]
Report on Unborn 2016-17	3.60	[2.04, 6.35]	1.78	[1.18, 2.68]	1.55	[1.14, 2.10]
DFV-related notification 2018	1.23	[0.86, 1.74]	0.99	[0.79, 1.24]	1.29	[1.09, 1.53]

PR = prevalence ratio, CI = confidence interval.

Table 16. Associations between having a DFV notification and **OOHC placement** in 2018.

	All children 2018 (N=3,315)	
	PR	**PR 95% CI**
Age (<1)	5.12	[2.51, 10.47]
Sex (Female)	0.88	[0.76, 1.01]
Aboriginal and/or Torres Strait Islander peoples	1.29	[1.11, 1.50]
Notification 2016-17	0.73	[0.61, 0.87]
Investigation 2016-17	2.19	[1.78, 2.68]
OOHC placement 2016-17	2.50	[1.88, 3.33]
Service provision 2016-17	2.49	[1.88, 3.29]
Report on Unborn 2016-17	2.76	[2.09, 3.65]
Notifications 2018	7.85	[6.33, 9.75]
DFV-related notification 2018	1.00	[0.85, 1.18]

PR = prevalence ratio, CI = confidence interval.

Table 17. Associations between having a DFV notification and referred to a **service** in 2018.

	1 notification 2018 (N=2,008)		**≥ 2 notifications 2018** (N=1,307)		**All children** (N=3,315)	
	PR	**PR 95% CI**	**PR**	**PR 95% CI**	**PR**	**PR 95% CI**
Age						
<1	-	-	-	-	-	-
1	0.58	[0.31, 1.11]	0.45	[0.11, 1.81]	1.08	[0.50, 2.36]
≥2	0.07	[0.04, 0.13]	0.18	[0.05, 0.70]	0.27	[0.13, 0.58]
Sex (Female)	1.21	[0.95, 1.55]	0.88	[0.72, 1.07]	0.94	[0.81, 1.08]
Aboriginal and/or Torres Strait Islander peoples	1.08	[0.79, 1.47]	1.28	[1.05, 1.57]	1.56	[1.34, 1.82]
Notification 2016-17	2.05	[1.55, 2.71]	1.08	[0.85, 1.37]	1.65	[1.38, 1.97]
Investigation 2016-17	0.33	[0.21, 0.50]	1.63	[1.25, 2.13]	1.56	[1.26, 1.93]
OOHC placement 2016-17	1.12	[0.69, 1.82]	2.66	[1.81, 3.92]	3.03	[2.17, 4.23]
Service provision 2016-17	64.60	[41.44, 100.72]	2.65	[1.82, 3.86]	3.86	[2.80, 5.33]
Report on Unborn 2016-17	1.34	[0.70, 2.58]	1.57	[1.02, 2.41]	1.26	[0.91, 1.73]
DFV-related notification 2018	0.74	[0.48, 1.14]	1.12	[0.90, 1.40]	1.42	[1.20, 1.68]

PR = prevalence ratio, CI = confidence interval.

Table 18. Associations between having a DFV notification and receiving a s a **service** in 2018.

	All children (N=3,315)	
	PR	**PR 95% CI**
Age (<1)	5.55	[2.72, 11.32]
Sex (Female)	0.90	[0.78, 1.02]
Aboriginal and/or Torres Strait Islander peoples	1.35	[1.17, 1.55]
Notification 2016-17	0.99	[0.85, 1.17]
Investigation 2016-17	1.44	[1.19, 1.74]
OOHC placement 2016-17	2.44	[1.86, 3.22]
Service provision 2016-17	3.26	[2.50, 4.26]
Report on Unborn 2016-17	2.21	[1.65, 2.96]
Notifications 2018	8.66	[6.94, 10.80]
DFV-related notification 2018	1.10	[0.94, 1.29]

PR = prevalence ratio, CI = confidence interval.

4. Limitations

The data that was used in this project was extremely rich, however there were limitations. Firstly, the substantiated grounds dataset was incomplete. In the dataset provided by DCP for 2016, 277 had 'Substantiated' as the investigation outcome. Of those, only 47 (17%) had a corresponding entry in the substantiated grounds dataset. This means that the alleged ground that was substantiated could not be determined for most substantiated notifications which results in an incomplete understanding of the children's experiences. Another concern is that the experience of DFV may not have been accurately captured in the alleged ground codes. In 2016, 31% of children reported to DCP in the Southern Metropolitan Region of Adelaide had a notification with a DFV-related alleged ground. Estimates of the co-occurrence of child abuse and neglect with domestic and family violence range from 30-50% (Richards, 2011; ALRC, 2010). It is, therefore, possible that the experience of DFV in the population of interest was higher. As well as this, there are several factors that are known to predict child abuse and neglect that were not available in the data. For example, parental child abuse, parental age and family size can all predict greater risk (Begle et al, 2010). Having data on these variables to include in the modelling, thus controlling for their influence on the outcomes, could have strengthened the findings.

5. Concluding remarks and recommendations

The aim of this study was to map the pathways and experiences of children who were subjects of child protection notifications and identify how the child protection agency responded to those children who experience DFV, compared to children who were not identified as experiencing DFV. In mapping children's journey and intervention responses within the context of child protection, the findings identified opportunities for early intervention and potential collaborative responses for children and their families who experience DFV. Such opportunities can potentially improve safety and wellbeing outcomes for children and reduce further likelihood of coming into contact with the child protection system. This research extends upon previous research conducted across three Australian states, that examined pathways through child protection systems (Ma et al., 2017; Shlonsky, Ma, Jeffreys, Parolini, & Katz, 2019). Here, the analysis of child protection responses specifically in the Southern Metropolitan region of Adelaide in South Australia, controlled for the impact of demographic and risk profile variables, and assessed additional outcome measures, including substantiation. We examined the impact of DFV on contact with DCP with demographic and risk profile variables as covariates separately, as well as in 'full' models that included all variables. The findings indicated that, even with controlling for the impact of demographic variables and previous contact with DCP, children with DFV

concerns in 2016 were: 1) less likely to have a notification investigated; but 2) more likely to have harm substantiated, commence OOHC placement, be referred to a service and be re-reported to DCP in 2017-2018.

The findings that children who experience DFV and are the subjects of child protection notifications were less likely to be investigated is both consistent with previous findings and suggests limitations in statutory responses and system capacity. Statutory organisations may have the limited capacity to respond to all cases of children who experience DFV. It can also suggest that assessments are not DFV informed which may lead to a minimisation of severity and accumulative impact of violence on the children's safety, development, and wellbeing. The percentage of children with a DFV concern who were the subject of an investigation was lower than that for the children without a DFV concern. In multiple variable analysis controlling for demographic and child protection history, children reported for a DFV concern in 2016 were less likely to have an investigation that year. This finding is consistent with what was reported previously from data across three Australia states (Ma et al., 2017; Shlonsky et al., 2019). In addition, we found that Aboriginal and Torres Strait Islander children were more likely to the subject of an investigation than non-Indigenous children, whether they were reported for DFV concerns or not. Despite this, Aboriginal and Torres Strait Islander children were as likely to have a substantiation if they had a DFV concern compared to non-Indigenous children.

Child protection systems are equipped to assess and respond to immediate harm and therefore are predominantly driven by responding to incidents, and to minimise risk to children's immediate safety. However, in terms of DFV, this analysis found children with a DFV-related notification were less likely to have an investigation but more likely to have a further notifications and substantiation into the future. Many children, both Indigenous and non-Indigenous, who experience DFV are subjected to a pattern of behaviour perpetrated over time which may contribute to physical, sexual, emotional abuse and neglect. Living in this context of complexity and chronic episodes of maltreatment contributes to experiences of cumulative harm. Although cumulative harm is a recognised child protection concern it is mostly a secondary interest in determining statutory intervention (Sheehan, 2018). These findings reinforce the understanding that there are valuable and missed opportunities for early intervention, within the context of child protection, for those children and their families where DFV is present, to intervene to reduce complexity and experience of cumulative harm. When a child/ren and young people are subjects of notifications where DFV is identified but do not meet the threshold for statutory intervention, those children and young people are deserving of early intervention to reduce further occurrence of harm or risk of harm occurring. Intervening at the earliest possible point allows for potential pathways out of the child protection system to specialist DFV agencies and/or intensive family support followed by warm referrals that are

focused on women and children's safety and wellbeing. It is also an opportunity for the service system to engage with men who choose to use violence and refer them to specialist domestic and family violence services. This is particularly important for Aboriginal and Torres Strait Islander children who were over represented in the child protection investigations. In addition, for those child/ren and young people who are screened in and assessed as requiring statutory intervention it is important to ensure that they and their families are referred to specialist DFV services ensuring that intervention is responsive to their safety and wellbeing needs with the aim of reducing further contact with the child protection system.

Recommendations include:

1. Create clearly defined indicators and/or codes for identifying and assessing DFV at the initial point of notification to child protection.
2. Increase capacity of the client information system to capture the recording of referrals made to specialist DFV services with some assessment about level of engagement with those services.
3. Identify opportunities for early intervention if children and young people who experience DFV do not require statutory intervention but ensure that children are referred to specialist DFV services and/or non-specialist services with the aim of reducing risk and enhancing safety and wellbeing.
4. Build clear referral pathways and protocols out of child protection if the threshold for statutory intervention is not met to specialist DFV agencies and/or intensive family support that are focused on women and children's safety and wellbeing.
5. Implement collaborative practice models between DCP and specialist DFV agencies promoting early intervention towards preventing or curbing cumulative harm.

6. References

Angela Moreland Begle et al (2010) Predicting child abuse potential: an empirical investigation of two theoretical frameworks, Journal of clinical child and adolescent psychology vol. 39,2 (2010): 208-19. doi:10.1080/15374410903532650

Aron Shlonsky, Jennifer Ma, Colleen Jeffreys, Arno Parolini & Ilan Katz (2019) Pathways of Children Reported for Domestic and Family Violence to Australian Child Protection, Australian Social Work, 72:4, 461-472, DOI: 10.1080/0312407X.2019.1624795.

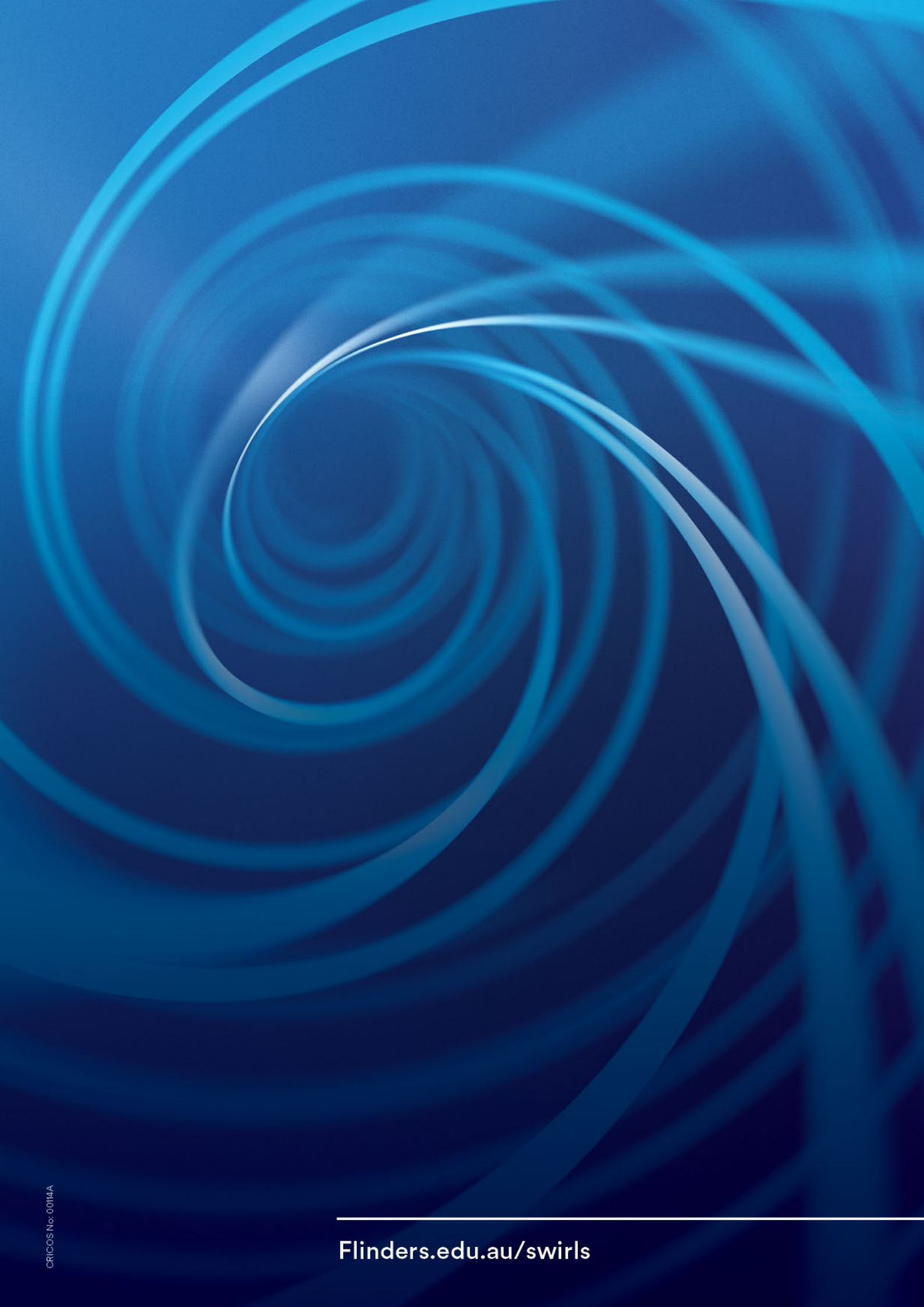
Cathy Humphreys, & Lucy Healey (2017) PAThways and Research Into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report (ANROWS Horizons 03/2017). Sydney: ANROWS.

Child protection Australia 2016-17 (2018), Australian Institute of Health and Welfare 2018, Child welfare series no. 68., Cat. no. CWS 63, Canberra: AIHW

Kelly Richards (2011) Children's exposure to domestic violence in Australia, Trends & Issues in Crime and Criminal Justice, https://www.aic.gov.au/publications/tandi/tandi419.

Australian Law Reform Commission(2010) *Interconnectedness of family violence and child abuse*. Australian Government, accessed September 2020 https://www.alrc.gov.au/publication/family-violence-a-national-legal-response-alrc-report-114/19-the-intersection-of-child-protection-and-family-laws-3/interconnectedness-of-family-violence-and-child-abuse/

Reporting and Statistics, Department for Child Protection, Government of South Australia, accessed September 2020 https://www.childprotection.sa.gov.au/department/reporting-and-statistics.



Flinders.edu.au/swirls

CRICOS No: 00114A

Appendix 2

Flinders UNIVERSITY

Social Work
Innovation Research
Living Space

SWIRLS

Social Work Innovation Research Living Space

Building collaboration at the intersection of domestic and family violence and child protection: KWY and DCP

Final Report

Dr Carmela Bastian

Professor Sarah Wendt

Dr Amy Bromley

August 2023

Acknowledgements

This report has been prepared by Dr Carmela Bastian, Professor Sarah Wendt, and Dr Amy Bromley.

We would like to thank Associate Professor Lorna Hallahan and Dr Jenny van der Arend, who were both involved during the establishment phase.

The research team in the Social Work Innovation Research Living Space (SWIRLS) extends thanks to the Early Intervention Research Directorate (EIRD) in the Department of Human Services for providing the funding for the postdoctoral program and supporting the establishment of the research agenda.

We begin with an acknowledgement of the Aboriginal and Torres Strait Islander children, families and communities who live with and experience family violence and the child protection system. It is important to recognise that the involvement of children and their families in the child protection system is reflective of intergenerational cumulative trauma as a result of colonisation, race-based policies, the Stolen Generation and racial inequality. Living in a context of violence brings them to the attention of services but should never diminish their dignity, cultural strength, and humanity. We strive to hear their voices and learn what factors contribute to the ongoing safety and wellbeing of children, families and communities.

We acknowledge the many conversations with many staff from KWY and DCP to enable collaboration. The specific details of this collaborative service response have been infused by the practice wisdom and enthusiasm of the practitioners who attended our co-design workshops and trialled collaboration efforts across 2 years of practice.

We would like to thank all staff and practitioners who dedicated their precious time to work alongside us to enable better outcomes for Aboriginal and Torres Strait Islander families.

Social Work Innovation Research Living Space College of Education, Psychology and Social Work Flinders University

South Australia

[redacted]

[redacted]

Contents

Table of Figures

The collaborative service response model facilitated a shift in language about family violence that informed a trauma understanding and response, where the perpetrator and his pattern of behaviours were up front and central in discussions, and in doing so, informed case direction and the necessary interventions.

Executive Summary

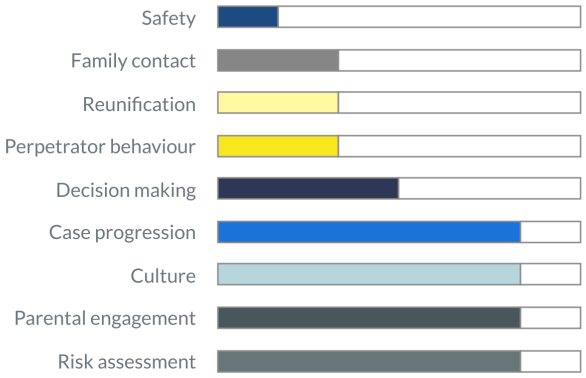
Integrating Aboriginal knowledge and expertise at both the operational and strategic level of governance presented a valuable opportunity for cultural voices to influence the larger service system.

Perpetrators were increasingly spoken about in case discussions, however, it was also found that children were not as visible as the perpetrator or the victim parent.

Families experienced complexity in addition to family violence, requiring holistic service delivery and intensive support to disrupt the chronic nature of the concerns.

Any attempts to separate family members did not reduce risk. Instead, the fear of separation led to the families hiding risk or added additional stress placed on the mother.

Focus of the Case Discussions



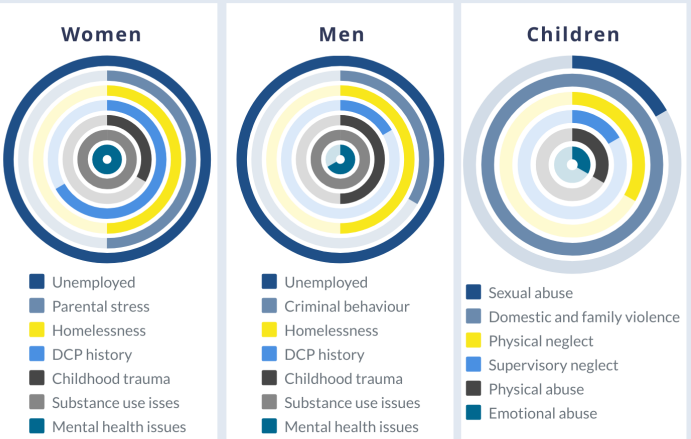
Summary Findings

The established processes embedded in the prototype also resulted in cultural and systemic changes and opportunities to share information within and across agencies which ultimately benefitted the families. Practitioners developed a shared understanding of domestic and family violence, risk, and cultural safety.

There were impediments to achieving effective collaboration such as diverse organisation philosophies and approaches, lack of information sharing, challenges surrounding resources, power dynamics between agencies, and communication issues.

Recommendations

- That DCP, in collaboration with KWY, review the prototype and consider embedding it across the organisation inclusive of communication and evaluation.
- That consideration be given to funding Specialist Liaison Officers across the regions of DCP to facilitate full implementation of the prototype.
- That DCP consider that the prototype be extended so that KWY and other Aboriginal practitioners be involved in the investigation and assessment phase of the child protection process to reduce the likelihood of Aboriginal children entering into out of home care.
- That DCP and KWY engage in further discussions to clearly understand how to effectively share risk and power so that decision-making and information sharing is truly collaborative and informed by domestic and family violence lens and cultural expertise.
- Enhance the visibility and inclusiveness of children and young people in discussions of collaboration.



Families wanted to remain together, with the perpetrator receiving support to change.

KWY supported the relationship between DCP and families.

Intergenerational trauma affected parental responsiveness to DCP.

"The purpose of these case discussions is that we share information openly and then, when we come to decision points, we make those together, as a collective. That's part of the model. I know DCP, in the past, have normally driven a lot of the decision-making process. This project is about watering that down and that we all take responsibility for this family and the decision making."

Introduction

The report provides an overview of work conducted between Kornar Winmil Yunti (KWY) and Department for Child Protection (DCP) at the intersection of domestic and family violence and child protection. The Social Work Innovation Research Living Space (SWIRLS) at Flinders University co-designed, collected data, and analysed practice at this intersection over two years. Funding was provided to SWIRLS by the Early Intervention Research Directorate (EIRD) to establish the Postdoctoral Fellowship Program for this specific project.

This report will outline the establishment and implementation of the collaborative service response. Professor Sarah Wendt and Dr Carmela Bastian worked closely with KWY and DCP in all phases of the project including establishing the authorising environment, observing case conferences, and interviewing families who were recipients of service provision by DCP and KWY simultaneously.

This final report of the collaboration between KWY and DCP is the culmination of more than two years work in the collection and analysis of data. Over the course of the project progress reports were submitted and various reports providing findings from various aspects of the research agenda. It is not the purpose of this report to duplicate findings from other reports but specifically provide an overview of processes and findings as it relates to building collaboration at the intersection of domestic and family violence and child protection involving KWY and DCP.

In this report we solely focus on collaborative practice that was developed and implemented for KWY and DCP to respond to children and families who experienced domestic and family violence (DFV).

Definitions

The following definitions are consistent with definitions that informed the collaborative service model or prototype.

Aboriginal and Torres Strait Islander Family Violence

The term, 'family violence' is the most widely used term to identify the experiences of Aboriginal and Torres Strait Islander people, because it includes the broad range of marital and kinship relationships in which violence may occur (Commonwealth of Australia, 2022). Whilst gendered drivers play an important role in shaping family violence in Aboriginal families and communities, colonisation is significant in shaping the underlying context for family violence.

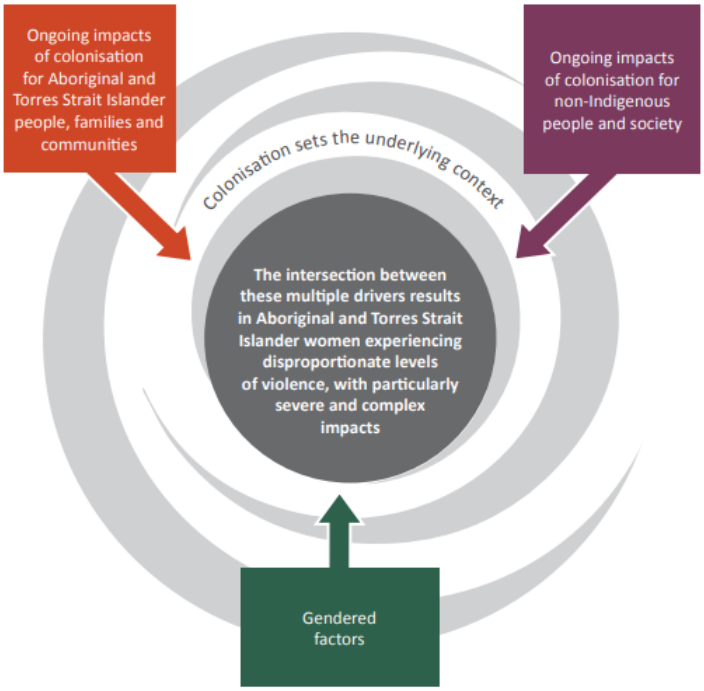
Colonisation has had ongoing impacts for Aboriginal and Torres Strait Islander people and society. Colonisation underpins racialized structural inequalities of power across society, and has shaped entrenched racism in social norms, attitudes and practices. This has created a context where racist violence can be perpetrated. It has also meant the condoning of, and/or insufficient accountability for, violence towards Aboriginal people. Violence is not part of traditional Aboriginal or Torres Strait Islander cultures. Further, violence against Aboriginal and Torres

Strait Islander women is perpetrated by Indigenous and non-Indigenous men. Racism is frequently an overt element of that violence when perpetrated by non-Aboriginal men (Our Watch, 2018).

Systemic racism, oppression and disempowerment are ongoing impacts of colonisation for Aboriginal people, families and communities. Race based policies that contributed to the Stolen Generation have created ongoing cycles of intergenerational trauma for Aboriginal families. Colonisation has destroyed and disrupted traditional cultures, family and community relationships and community norms about violence. Personal experiences of violence or exposure to violence have then also impacted the intergenerational and collective trauma experienced by Aboriginal people and communities (Our Watch, 2018; Blagg et al, 2015). Thus, it is the intersection of gender, colonisation and racial inequality that creates the conditions for disproportionate levels of violence against Aboriginal women and children (Our Watch, 2018; Blagg et al, 2015). Our Watch (2018, p14) illustrate this intersectionality via the following diagram:

Figure 1

The Intersectionality of Factors Affecting Aboriginal Family Violence



The term lateral violence has grown in prominence in Aboriginal communities in recent years. It describes "the way people in positions of powerlessness, covertly or overtly direct their dissatisfaction inward toward each other" (Cripps & Adams, 2014, p.400-401). Lateral violence occurs among Aboriginal people, and the root causes lie in colonisation, oppression, intergenerational trauma and ongoing experiences of racism and discrimination. Behaviours include gossiping; jealousy; bullying; shaming; social exclusion; family feuding; organisational conflict, and physical violence (Blagg et al, 2015). This violence can be expressed in episodes of rage and anger generating fear and terror on those family members who are closest and most vulnerable (Cripps

and Adams, 2014). This means that violence extends beyond the traditional victim/perpetrator dyad including other family members.

'Gender-based violence' refers to violence that is used against someone because of their gender. It describes:

> violence rooted in gender-based power inequalities, rigid gender norms and gender-based discrimination. While people of all genders can experience gender-based violence, the term is most often used to describe violence against women and girls, because most gender-based violence is perpetrated by heterosexual, cisgender men against women, because they are women (p. 35). Violence against women and girls is a manifestation of inequality and discrimination based on gender, race and other power imbalances. It is rooted in historically unequal power relations that view women and girls as subordinate to men and boys. Overwhelmingly, violence against women in Australia is perpetrated by men (p. 32).

Risk

The concept of risk is central to practice for both child protection and family violence practitioners. This risk may relate to immediate safety concerns or involve consideration of longer-term risks that are a consequence of the accumulation of harmful experiences over time. Developing shared understandings of risk, risk assessments and risk management, is challenging when working across contexts where there are different organisational imperatives and different practice approaches. Practitioners may have different experiences of working with the same family. There can be tensions associated with balancing risks where individuals in the same family have competing needs and interests. Actively involving families in understanding and managing risk across service provision contexts can contribute to the complexity but is essential for a whole of family approach.

For child protection, the primary focus of risk assessment and intervention is the child. Although recognising that the non-offending parent, who are predominantly mothers, are also victims of family violence the focus of child protection is predominantly on their parenting capacity. In many circumstances, the focus of intervention predominantly involves the mothers, and the fathers tend to retreat into the background (Stanley & Humphreys, 2014). KWY's unique service approach, which involves working with perpetrators, mothers and children, enables an assessment of risk and safety drawing on information gathered from all family members. This enables a more comprehensive understanding of risk and safety for families to be developed.

A comprehensive understanding of risk is required to inform management of those risks and the development of intervention plans. A comprehensive assessment of the factors that contribute to harm and danger is required, but it is also necessary to simultaneously explore strengths and safety. A comprehensive risk assessment is informed by professional knowledge but equally informed by the expertise and knowledge of families (particularly mothers and children) and other relevant key stakeholders (Turnell & Murphy, 2017).

Safety

Conducting comprehensive risk assessments informs risk management strategies and safety for women and children. Safety of children is the priority for child protection services and safety of women and their children is the key consideration for family violence specialist services. The challenge for this collaboration is to identify Aboriginal children and families as early as possible in the context of child protection, engage in shared decision-making processes and work towards the safety of women and children.

Safety involves the removal of risk factors and the enhancement of protective factors so that women and children can feel physically, emotionally and culturally safe. Achieving the safety of women and children also requires that the perpetrator's behaviours, and the impacts of these behaviours are visible and accountable. Perpetrator responsibility must be part of the conversations, so the impacts of their violent behaviour are recorded and reported. Achieving safety requires immediate responses by child protection and KWY. However, it also requires consideration of longer-term safety needs, which involves attending to family member's stability, security, healing and recovery. To achieve safety, family violence informed practitioners need to assess the uniqueness of each family situation and tailor responses to the holistic needs of individuals inclusive of connection to community and culture. If a child is removed for a period, safety also means ensuring connection to culture, kinship networks, to enable a sense of belonging and identity for Aboriginal children.

Background

Aboriginal children and their families are vastly overrepresented in the South Australian child protection system. Approximately 4.9% of children in South Australia are Aboriginal and/or Torres Strait Islander (2023), yet they comprise 39% of all children in out-of-home care (Productivity Commission, 2023). Longitudinal analysis shows that 25% of all Aboriginal and/or Torres Strait Islander children in South Australia will be the subject of a substantiated investigation and more than 12% will be placed in out-of-home care (OOHC) for some period of time (Segal et al., 2019). These numbers sit in stark contrast to those of non-Indigenous children in South Australia. The most recent data shows that Aboriginal and/or Torres Strait Islander children are 6.3 times more likely to be the subject of a notification, 11.5 times more likely to be subject to a substantiated investigation, and 12 times more likely to be placed in OOHC (Productivity Commission, 2023). Further, this disproportionality has increased in the last eight years since the Child Protection Royal Commission Report (Nyland, 2016).

The profound impact of children removed from their families and communities and intergenerational trauma is evident through issues such as family violence, substance abuse and loss of knowledge of cultural child rearing practices. Many children who are removed become disconnected from their culture and identity (Nyland, 2016). Additionally, a cycle is created whereby the intergenerational trauma contributes to risk for future generations. DFV has been identified as one of the primary drivers for Aboriginal children entering out of home care and contributing to their overrepresentation in the child protection system. (Family Matters, 2019; Our Watch, 2018).

When examining the impact of DFV on families, mothers and children are the primary victims. The National Plan to End Violence Against Women and Children (Commonwealth of Australia, 2022) identifies that 1 in 4 women has experienced DFV from an intimate partner by the age of 15, and that 95% name a man as the perpetrator of at least one incident of violence. Overall, around 4 in 5 DFV perpetrators are men. Aboriginal women are particularly vulnerable to experiencing DFV. They are 20 times more likely to be physically assaulted and 6 times more likely to be sexually assaulted when compared to non-indigenous women. Because of the clear, gendered pattern of violence in Australia, interventions are needed that are survivor-centred, holistic, and involve multiple sectors to ensure the needs of victim parents and their children are met (Commonwealth of Australia, 2022).

Research and interventions targeting DFV have often followed a western model which criminalises violence and separates the needs of victims and perpetrators, which is disempowering for Aboriginal communities (Blagg et al., 2015; Cripps & McGlade, 2008; Tarzia et al., 2017). It is against this backdrop that SWIRLS, KWY and DCP identified a valuable opportunity to develop culturally responsive practices. The aim was to improve outcomes for Aboriginal children, their families, and communities by focusing on the intersection of DFV and child protection. Understanding the historical context and experiences of children and families is particularly important to shape services that prevent and respond to DFV experienced by Aboriginal families and communities. Olsen and Lovett (2016) highlight principles that increase the effectiveness of interventions to DFV in Aboriginal communities. They advise that interventions should be focused on building family cohesion, healing individual and community trauma, and helping both victim and perpetrator deal with their pain and intergenerational trauma. These same principles underpinned the collaboration and coming together of KWY, DCP and SWIRLS.

There are significant strengths in Australian Aboriginal cultural practices in family life and child rearing. Particular strengths that have been identified include community and kinship responsibility for the rearing and protection of children; providing children with every opportunity to be safe while nurturing their wellbeing, recognition and respect for Aboriginal elders and their role in caring for children, and attention to spirituality and social networks (Lohoar et al., 2014). Aboriginal child rearing and commitment to family and community is a protective mechanism that has not always been recognised. For example, in South Australia, it was not until 1967 that Aboriginal children were fostered with Aboriginal families, and many were still being adopted by non-Aboriginal people. Further, it was not until 1972 that the Community Welfare Act established the Department of Community Welfare and repealed separate legislation relating to Aboriginal people. This legislation had remained underpinned by the protectionism and assimilation policy approaches in place since Australia's colonisation. Despite the new policy emphasis influencing child protection, a disproportionate number of Aboriginal children continued to be removed from their families and communities.

The Child Protections Systems Royal Commission Report stated that greater attention should be paid to the specific needs of Aboriginal communities and families (Nyland, 2016). The report advised assisting communities and families to care safely for children and helping Aboriginal children in care retain connections to their community and culture. The South Australian Government has enacted a range of commitments to address the

Commission's recommendations for Aboriginal children and families and supports the Family Matters campaign. In addition, DCP has implemented the Aboriginal Action Plan 2021-2022 (South Australian Department for Child Protection, 2021). The Action Plan acknowledges the Aboriginal and Torres Strait Islander Child Placement Principle as a guiding framework for action and commits to active efforts across each of the five core elements – Prevention, Partnership, Placement, Participation and Connection. The Action Plan, and previous versions, provided an important framework for this collaboration to be more responsive to the needs of Aboriginal children and families.

Developing a stronger connection between child protection and DFV specialist services has not always been a priority because of historical tensions and organisational silos that have shaped practice in these contexts. Yet, collaboration can realistically make a difference when combined with key elements such as shared understanding of culturally responsive practice, clear governance, managerial commitment, and establishment of a learning culture. It was these key elements that we utilised to bring collaboration to the forefront of practice at the intersection of child protection and DFV. The key elements were operationalised via specific and shared practical structures, resources, and tools to bring them to life within the project. This report outlines our endeavour to engage with such elements and build evidence of collaborative practice.

The Collaborators

Child Protection

The Department for Child Protection (DCP) is the statutory child protection organisation in South Australia. DCP is responsible for the administration of the Children and Young People (Safety) Act 2017, Children and Young People (Safety) Regulations 2017, and Family and Community Services Act 1972. DCP is responsible for:

- responding to concerns about children and young people who have experienced harm or are at risk of harm
- placing children and young people in care when they are unable to live safely with their families
- providing case management and support for children and young people under the custody or guardianship of the Chief Executive
- supporting the reunification of children and young people with their families where it is safe to do so
- managing the adoption process
- supporting children and young people from a refugee background through the Commonwealth Guardianship team.

The aim of statutory intervention is to ensure the safety of the child by facilitating change in the family circumstances. Change in circumstances must ensure the safety of the child through reduction of risk factors such as no longer living in a context of violence; safety planning to reduce violence; and change in living arrangements. There must also be an increase in protective factors such as active engagement with services, the Victim parent and child receiving support that meets their needs, the perpetrator being visible and

accountable, and the engagement of protective extended family members. If the child and the Victim parent continue to experience violence and the perpetrator is unwilling to engage in safety planning and change, the child/ren may be at risk of removal. In extremely high-risk situations, and where neither parent is able or willing to provide a safe environment, children may be removed from their biological families and placed in out of home care. For some of these children, plans for reunification or establishing best connection have been actioned and DCP staff provide case management services to ensure the long-term safety and wellbeing of the child.

KWY

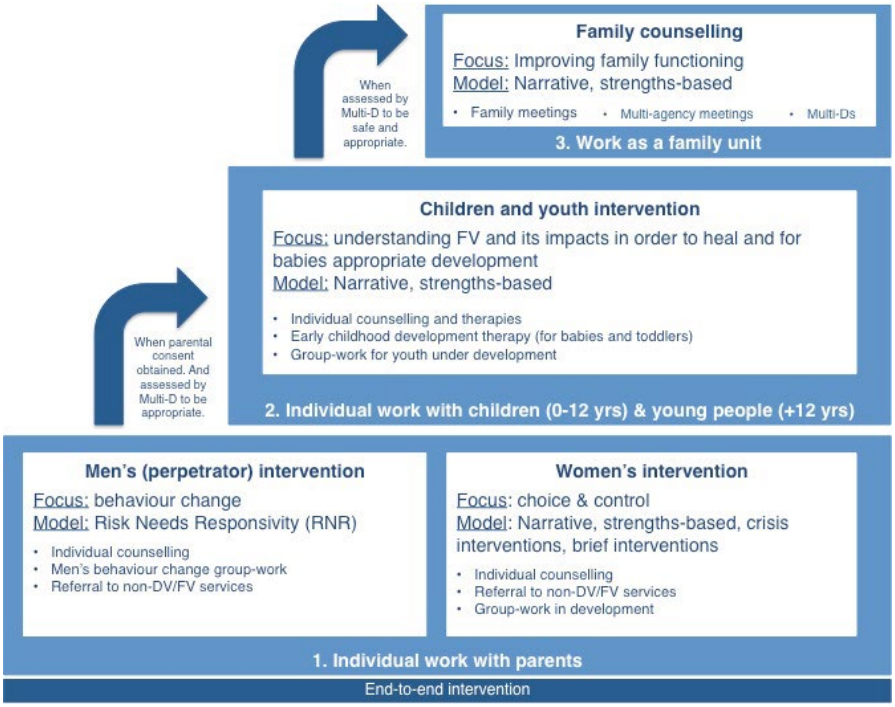
KWY's Stronger, Safer Families Outreach Hub (SSFH) provides culturally responsive, trauma-informed therapeutic intensive family case management services to Aboriginal and/or Torres Strait Islander children, parents and families who are experiencing DFV. The Hub aims to reduce and cease violence and its impacts in Aboriginal and/or Torres Strait Islander families. Children and their families may enter the KWY services via different pathways including self-referral, referral from another part of the agency, referral by another agency, or referral through an informal support such as friend or family.

The Hub's model is underpinned by a family-led decision-making approach to working with all families, where they are empowered as decision-makers from the very first contact with KWY. Family-led decision making is further underpinned via the application of strengths-based, narrative and problem-solving theoretical approaches to practice. KWY's experience has indicated that intervening earlier with families enables more scope for family-led decision-making in practice. The early focus of KWY's work is on stabilising the family and addressing risk and safety. Initial contact with families emphasises engagement, trust-building, and helping families to address their immediate needs (particularly safety needs). Achieving safety and stability are important in order to be able to maximise the capacity of families to make decisions about the best way to respond to the range of issues that are contributing to their situation.

The Hub provides intervention to eligible families to reduce or cease family violence and its impacts at two levels. At the individual level, women, men and the children receive individualised support to assist them to understand family violence, the impacts of violence, and address the trauma associated with family violence. This involves intensive work with the perpetrators so that they are visible and accountable and accept responsibility for and reducing/ceasing their violent and controlling behaviours. Intervention also occurs at the family level, when safe and appropriate, to improve family functioning. KWY, through its holistic family approach, ensures practitioners can monitor and support the safety of women and children. Support workers work closely with the women and children, whilst men's family violence workers simultaneously work with the perpetrator. Collectively, workers share information allowing ongoing, real-time, risk assessments and co-ordinated responses for children, women and men. The model is illustrated in Figure 2.

Figure 2

KWY Intervention Model



KWY's intensive case management services for men, women and children adopts a strengths-based and therapeutic approach. The work with men places perpetrators in view and engages them through working with them one to one and men are also invited to attend a men's behaviour change group so that they take responsibility for changing their behaviour and choosing to end their use of violence. Women are enabled to focus on healing through one-to-one work and they are also invited to attend group work focused on healing and recovery. The intervention with women includes rebuilding relationships with their children, rather than being expected to manage the risk associated with the actions of perpetrators. Finally, the service also has integrated trauma-informed services for children using a blend of traditional cultural activities and contemporary psychology however throughout most of the trialling and testing of the prototype KWY did not have a children's worker due to recruitment issues. Families are assisted to connect with other required services (e.g. drug and alcohol; mental health), to support their plan for safety and wellbeing. This approach is shown in Figure 3.

Figure 3

KWY Approach to Promoting Family Safety

Methodology

Please note, methodology described below received approval through the Flinders University Human Research Ethics Committee (Approval 2731) and the Aboriginal Health Research Ethics Committee (Approval number 04-19-818).

Design

The trialling of collaboration between KWY and DCP at the interface of DFV and child protection adopted a place-based methodology, with a focus on enhancing practice in the Southern Metropolitan region of Adelaide. Place-based approaches to service design, management, and evaluation involve the development of collaborative and flexible responses to local needs by drawing on data, evidence, and local experiences to guide practice and innovation. They are an effective means for addressing 'wickedly' complex issues that have many interacting causes and require multiple actors to develop a co-ordinated response (Moore, 2014; Moore & Fry, 2011). This place-based approach enabled KWY and DCP to concentrate on relationship-building and collaboration amongst the complexity of DFV and child protection, which allowed the development and implementation of a co-design approach to supporting Aboriginal families and children.

Aims

The specific aims of the collaboration effort between KWY and DCP were to:

- develop an understanding about the specific ways in which Aboriginal families experiencing DFV and child protection concerns navigate and interact with the service systems.
- co-design, trial, and test sustainable collaboration practice across DCP and KWY so that children could be potentially reunified with families.
- document and measure outcomes for children and families who received services linked to the newly established collaborative practice effort.
- identify strengths and limitations in practice that facilitate or impede collaboration and hence influence safety, healing and recovery of children and families.
- translate findings to inform workforce development, practice, and service design between child protection and specialist DFV services.

Establishing an Authorising Environment

To build the possibility of collaboration between KWY and DCP, the trial required the establishment of an authorising environment where there was strong leadership and formalised governance processes. The term 'authorizing environment', is derived from public value theory (Moore, 1995) and refers to the

> *"legitimising of processes within and across systems. Collaboration within an authorising environment have clear expectations mandated by bodies – government and non-government – to whom the collaboration is accountable"*
>
> *(Connolly et al., 2017, p.7)*

The importance of establishing this environment is exemplified in the publication PAThways and Research into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: the PATRICIA Project (Humphreys & Healey, 2017). In the work between DCP and KWY, this authorising environment was established. Senior and relevant stakeholders mobilised the shared vision of collaboration into the practice of two DCP offices in the Southern region of Adelaide. The founding of an Advisory Group, to initiate the collaboration endeavour, was critical in legitimising practice change across and between KWY and DCP. The Advisory group included senior staff members from DCP and KWY and senior Aboriginal practitioners from both organisations and was responsible for overseeing strategic and operational concerns associated with collaboration at the intersection of child protection and DFV concerns. Through their joint leadership, they guided and provided accountability to the collaborative effort. Some members of the Advisory group also participated in the co-design of the prototype built to enable active collaborative practice (detailed below).

The formalised governance structure enabled professional relationships to form across DCP and KWY because there were clear expectations relating to accountability to each other. This is an important aspect of collaboration within an authorising environment. For example, the co-designed workshops produced formalised, collaborative practices and new working arrangements, including information sharing and risk assessments that both parties

agreed to. More importantly, these co-designed collaborative arrangements enabled space for reflection and discussion of challenging issues during the trial of the prototype. This resulted in a commitment to shared decision making at the DFV and child protection to improve outcomes for practitioners, children, and their families.

Collaborative Practice: Co-designing a Prototype.

Co-design workshops were convened to develop a prototype to build collaboration at the intersection of child protection and specialist DFV practice when working with Aboriginal families.

Two workshops were held with staff from DCP and KWY. The workshops were held on 30 September and 16 October 2019 and each lasted four hours. KWY staff (operational and leadership) from the Southern Regional Hub attended as well as the CEO of the organisation. The meeting was also attended by DCP staff including leadership staff from the Southern Region and supervisors and senior practitioners from the Noarlunga and St Mary's offices.

The first workshop focused on building relationships and staff becoming familiar with each other's organisational mandate and operations. The participants of the workshops then spent time discussing the following:

- principles for the collaboration
- reaching consensus about what collaboration looks like at the intersection of child protection and DFV
- identifying the key elements required to achieve collaborative practice between DCP and KWY.

The discussions and decisions made at the first workshop were written into a draft prototype which then was used to inform the second co-design workshop. The first workshop generated rich discussions that predominantly focused on the necessity for improved collaborative practice that was culturally responsive and respectful of Aboriginal practitioners and families.

The second co-design workshop was convened on 16 October 2019. The focus of the second workshop confirmed with the participants that the draft prototype was consistent with previous discussions followed by finetuning prior to implementation. The prototype was redrafted and sent to all participants for any further comments. Prior to release of the prototype, approval was sought and given by all Aboriginal practitioners who attended the co-design workshop. The endorsement from the Aboriginal practitioners was imperative as a central objective of the prototype was to enhance cultural responsiveness and improved outcomes for Aboriginal children and families.

At the end of the co-design process the prototype was ready for implementation. The prototype functioned as a framework that highlighted the key pathways and indicators that would facilitate collaboration. This report shares findings and learnings from actively using this prototype to enable collaboration at intersection of DFV and child protection concerns.

Collaborative Service Principles

- **The safety** of children and their mothers is paramount.
- Practice will be culturally responsive.
- **Relationships amongst all professionals will be respectful.** Professionals will recognise and value each other's expertise. Differences in personal and practical understandings will be negotiated respectfully to achieve outcomes.
- **Relationships with families will be respectful.** Professionals will value families' unique knowledge and expertise. Professionals will support families' agency and decision-making in the development and implementation of plans to ensure their own safety and wellbeing.
- Collaborative service responses will be child and family focused and solution focused.
- Practice will be underpinned by **shared language and understandings** about family violence and child protection.
- There will be a commitment to open and ongoing conversations and i**nformation sharing** will be ethical**.**

Practice Foundations

Family violence informed

Family violence informed practice is underpinned by a strong working knowledge of the drivers and impacts of family violence for individuals, families, communities and culture. Violence against Aboriginal children and women must be understood within the specific historical context of colonisation, oppressive and racist policies, and systemic disadvantage. Understanding the multi layered factors that contribute to family violence in Aboriginal families and communities means that we cannot employ "mono-causal explanations for family violence such as the male power model" (Blagg et al., 2015, p.4). This working knowledge enables practitioners to fully appreciate the complexity of the children and families experience and must encompass a wide range of physical, emotional, sexual, social, spiritual, cultural, psychological and economic abuses that occur in the family.

Family violence informed practitioners recognise the importance of:

- assessing and validating the experiences of the victims of family violence;
- maintaining a strong focus on the perpetrator's behaviours and the impacts of those behaviours; and
- holding perpetrators accountable for their behaviour;
- ensuring that assessment and intervention is holistic and linked culturally inclusive.

Practitioners who are family violence informed begin their risk assessment with understanding the pattern of the perpetrator's behaviour and how this impact on the children, their mothers and family functioning. Safety planning and intervention can then be undertaken. This ensures the immediate safety of family members in the first instance, but also addresses their ongoing safety needs.

Culturally responsive

Culturally responsive is acknowledging that culture is central to the health and wellbeing of Aboriginal and Torres Strait Islander people. In understanding the importance of culture promotes practice that is inclusive of Aboriginal and Torres Strait Islander worldviews. The social, emotional, wellbeing of Aboriginal and Torres Strait Islander individuals, families and communities are interconnected and shaped by connections to body, mind and emotions, family and kinship, community, culture, land and spirituality (Commonwealth of Australia, 2017; Gee et al., 2014).

Figure 4

The Determinants of Health and Wellbeing for Aboriginal and Torres Strait Islander People

(Gee et al., 2013)

The interconnected social, emotional and wellbeing of Aboriginal and Torres Strait Islander people must be considered within the broader social, cultural, political and historical contexts; for it is only when we recognise these contexts can we see the impact of colonisation. *Social determinants i*nclude factors such as socioeconomic status, the impact of poverty, unemployment housing, education, racial, discrimination, exposure to violence, trauma and stressful life event. These factors often do not occur in isolation but are interrelated and cumulative. *Historical determinants* refer to the impact of past government policies and the extent of historical oppression and cultural displacement experienced by individuals, families, and communities. *Political determinants* refer to the unresolved issues of land, control of resources, cultural security and the rights of sovereignty and self-determination (Dudgeon & Walker, 2015).

Culturally responsive practice includes:

- • holding the culture as central to Aboriginal and Torres Strait Islander health and wellbeing
- • involves ongoing reflective practice and life-long learning

- • is relationship focused
- • is person, family and community centred
- • appreciated diversity between groups, families and communities, and
- • requires access to knowledge about Aboriginal and Torres Strait Islander histories, peoples and cultures (Indigenous Allied Health Australia, 2015)

Culturally responsive practice with Aboriginal families begins by recognising the intergenerational trauma that results from the cumulative impacts of colonisation - including the dispossession of land, loss of language and culture, erosion of cultural and spiritual identity, the forced removal of children – and from ongoing racism and discrimination (Our Watch, 2018).

Family-centred

Family-centred practice is based on the understanding that all families are different, and that practice needs to reflect the uniqueness of each family to achieve good outcomes. Aboriginal families are extremely diverse in terms of their structure or dynamics, with men, women and children being related by varying blood, marriage, kinship, or other significant relationships. Whatever form a family takes, it is important to recognise that strong families are pivotal to the health and wellbeing of Aboriginal communities.

Family-based practice involves the creation of respectful family-practitioner partnerships, where families lead on decision-making and intervention focuses on strengthening and supporting family functioning. Intervention is individualised, flexible and responsive to family defined needs, aspirations and strengths. Families and practitioners are mutually responsible for achieving their mutually agreed practice goals. Power inequalities are recognised, and sincere attempts are made to share power. Family-centred practice requires:

- a high degree of clarity about family-defined desired outcomes;
- clear and agreed steps for achieving outcomes;
- a shared understanding of indicators that these outcomes are being attained;
- clearly defined roles and responsibilities; and
- decision making processes and conflict resolution mechanisms that are transparent (Scott, 2005; Trute & Hiebert-Murphy, 2013).

Trauma-informed

Trauma-informed practice is built on an understanding of the pervasiveness of trauma and its impact for families. Trauma can be experienced individually and/or collectively. Individual trauma refers to an individual's experience of an event or events, and can impact an individual across physical, social, and emotional domains. Collective trauma refers to the impact of traumatic events on the functioning of a group, such as a family, or a community. Families may also experience historical, or intergenerational trauma, which refers to the cumulative historical and psychological damage that has occurred over a lifespan and across generations (Harris & Fallot, 2001). For Aboriginal families and communities, it is important to recognise that the trauma of colonisation is not just

associated with events in the past, but frequently continues via oppressive understandings and practices that have become institutionalised today.

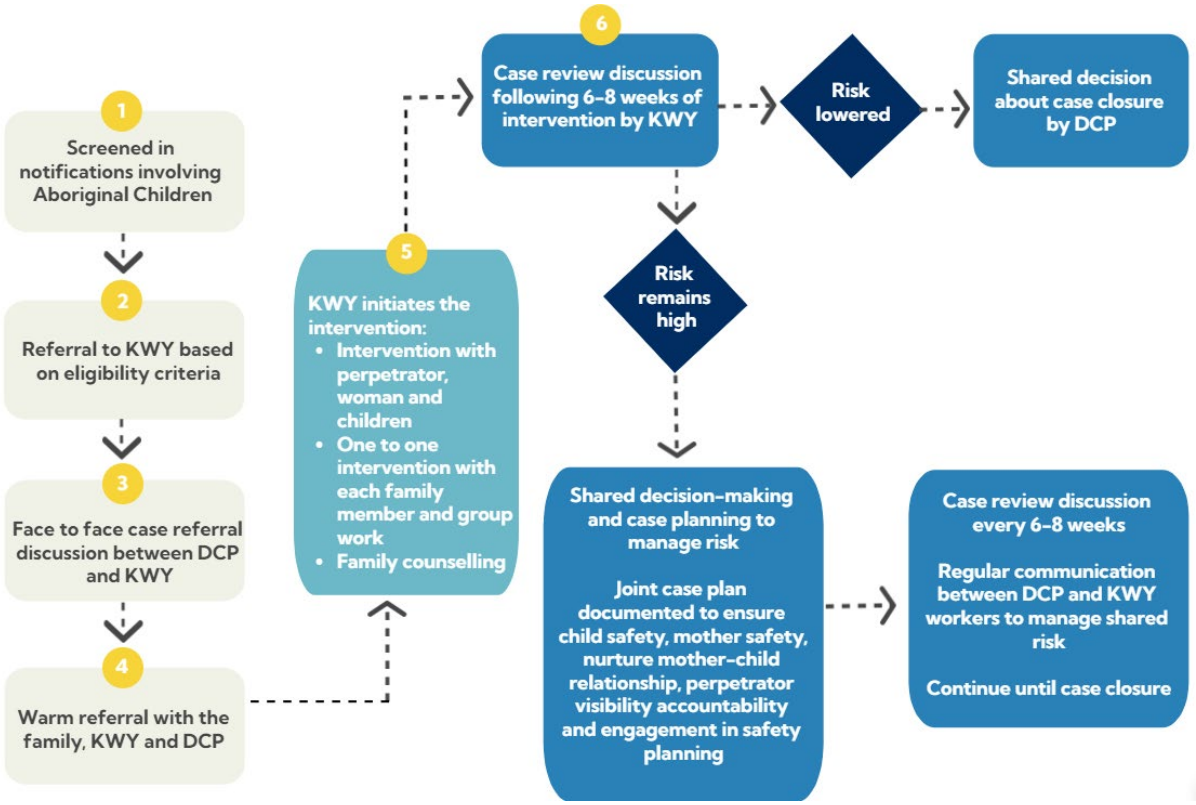
Central to a trauma-informed perspective is an approach that shapes service responses from a vantage point of "what happened to you" rather than "what's wrong with you". Trauma-informed practitioners recognise that individual's and families' behaviours are most often survival strategies - and focus on family member's individual and collective strengths. Trauma-informed services are based on principles of respect, dignity, inclusiveness, trustworthiness, empowerment, choice, connection, and hope. Practice aims to attend to families' physical and emotional safety, to avoid retraumatising families, to support healing and recovery, and to facilitate meaningful participation of families in the design, implementation, and evaluation of services (Warshaw et al., 2013; Wilson et al., 2015).

The prototype – collaborative service model

The prototype co-designed amongst DCP, KWY and SWIRLS is outlined in Figure 5.

Figure 5

The Key Processes of the Collaborative Service Model (Prototype)



The key elements of the prototype included the following:

1. The **eligibility criteria** for referrals from DCP to KWY need to include children and/or family members who identify as Aboriginal or Torres Strait Islander, family violence has been identified as risk factor and does not have to be the only risk factor, adults in the children's family environment continue to be connected although don't need to be living together, and child/children are in the care of mother or perpetrator and continue to be impacted by the violence.
2. The prototype and practice were informed by a **cultural lens**. Culturally safe and responsive practice was to be achieved by the inclusion of Principal Aboriginal Consultants from DCP and KWY staff. The prototype also specified that the practice must be informed by DCP's Aboriginal Action Plan 2019 -2020. Importantly the culturally informed approach is also consistent with ensuring that family safety and strengths is prioritised by including their voices and promoting family led decision making.
3. Once referral accepted by KWY a face to face to **referral discussion** was convened by the SLO between KWY and DCP.
4. The next stage was to organise and follow through with a **warm referral**. Staff from KWY and DCP organised to meet with family to ensure transparency about the process and referral to KWY. The family were informed that KWY and DCP were working together, and the roles of the agency (statutory and non-statutory) was clearly conveyed to the families. The final stage of the warm referral process was to seek consent from the family to work with KWY and open communication between the agencies.
5. The prototype also stipulated the importance of **open communication, sharing of information, and sharing of risk.** Regular communication established between KWY and DCP depending on level of risk to discuss risk assessments and intervention with family. For example, if high risk at least weekly communication via telephone, email and/or online discussions via MS Teams. During KWY intervention it was agreed that DCP kept case open at least until the first case review discussion. Keeping the case open by DCP supported the referral process, the whole of family assessment, plans for intervention, and ensure that families continue to engage in the change process. This **communication strategy** and keeping the case open by DCP facilitating the convening of **urgent meetings** if risk to the child due to family violence or other risk factors increases or does not reduce, additional notifications are received by DCP, and if family failing to engage in intervention with KWY.
6. **Intervention** following acceptance of referral by KWY included intervention at the individual level - (women (mother), men (father) and children / youth receive individual support to asst them understand family violence and its impact on them to assist them to work through the trauma it has created. For perpetrators, the intervention focuses on them taking responsibility for, and reducing / ceasing their violent and controlling behaviours. Intervention at the family level. When safe and deemed appropriate to do so, work is undertaken with the family unit to improve family functioning.
7. **Case review discussions** were convened by the SLO after 6 – 8 weeks of KWY intervention. The case discussion meetings were attended by the KWY team working with the family, DCP case manager, DCP

supervisor and Principal Aboriginal consultant. Meetings would not be convened unless the Principal Aboriginal Consultant was present to ensure a culturally responsive approach. The focus of the meetings were to share information about the progress of the family and level of engagement, assessment of risk and needs, shared information about the perpetrator behaviours, safety and wellbeing of women and children, cultural considerations, and decision making about progress of the case.

a. **Risk has lowered - Decision making** that occurred when there was lowered risk **to the child/ren** was whether DCP would cease to be involved with the family or keep the case open while further intervention occurred with DCP.
b. **Risk continued to be high –** for families where risk continued to be high KWY and DCP continued to work together to develop a **shared case plan and share risk** by identifying shared priorities, shared culturally specific understanding of family violence through identification of risk and safety for mother and child/ren, where possible use culturally specific and relevant assessment processes, and share expertise and risk across the two agencies. It was expected that the shared case plan would identify roles and responsibilities, what further intervention is required to reduce risk, develop a clear communication strategy, and how to increase family connection to culture. The cycle of 6 – 8 weekly case reviews will continue until there is shared decision-making process assessing that risk is lowered or the case is closed.

Employment of Specialist Liaison Officers (SLO)

The authorising environment also enabled a position titled Specialist Liaison Officer (SLO) to build the practice infrastructure and sustain the trial of the prototype. This was a newly created position funded by DCP. The position was managed and situated within KWY to support building collaboration. The role and function of the SLO was to lead the implementation of the prototype service model at the practice level across both DCP and KWY. Their role and responsibilities included leading case discussions and case reviews, facilitating families to be interviewed, and identifying any issues that emerged in relation to the implementation of the prototype. The SLO became the contact point between the organisations in relation to information sharing and specialist consultations about referrals and service provision.

KWY were provided funding by DCP for 12 months. The funding was to facilitate collaborative practice between the organisations. KWY received $157,066 in November 2019 however had some difficulties in filling the position. The position was filled for a short time in March/April 2020, was vacant for a period of time but then filled in mid-October 2020.

Working Group

A working group of members comprised of KWY and DCP practitioners organically formed following the co-design process and implementation of the prototype. The working group provided leadership to develop,

implement, and monitor practice change across the collaborative arrangements testing the prototype. In addition, the working group had a significant role in communicating the collaborative project aims with frontline practitioners. This occurred through the facilitation of information sessions or workshops as well as providing networking opportunities between practitioners from the different sectors. In this way, the working group provided the authorising environment infrastructure; facilitated a formative evaluation of the collaborative practice, and defined the operations and roles to which each organisation would be accountable. They met on monthly basis.

Recruitment and Sample

The focus of the collaborative practice was to provide earlier intervention to Aboriginal children and their families who were experiencing DFV and assessed as requiring a statutory response. The specific target group included the following eligibility criteria:

- The notification had been received by the Department for Child Protection involving Aboriginal children and their families and DFV was identified as one of the significant factors.
- The notification fell within the jurisdiction of the either Noarlunga or St Mary's DCP office (Southern metropolitan region) for determination of further action.
- The child/ren, who were subjects of the notification, were living in a family environment and experiencing DFV.
- The child/ren were in the care of the Victim parent and/or the perpetrator.
- One or more members of the family identify as Aboriginal or Torres Strait Islander.
- The perpetrator was connected and continued to be present in the lives of the children and the Victim parent. More specifically, the adults (inclusive of extended family members) were in a continuing relationship even if not currently living with each other.

All couples within the start and end date of the study agreed to be interviewed, resulting in six families included in analysis of the prototype between KWY and DCP. An overview of each of the families is presented in Table 1. A more detailed analysis of each case is presented in Appendix 1.

Table 1

Overview of the KWY Sample

Please note in terms of collaboration:

High = frequent case discussions AND some shared decision making OR consultation prior to decision-making

Moderate = regular but infrequent case discussions OR frequent case discussions but no shared decision-making

Low = few to no case discussions AND no shared decision-making OR other strong barriers to communication.

Family intervention	Key characteristics	Level of collaboration	Outcome
BA Family • 12-month intervention • 5 case discussions • 1 adolescent • 3 school aged children	• The parents initially separated but later resumed their intimate relationship. • The perpetrator did not engage with any services. • The perpetrator was incarcerated at the start of the intervention. • The organisations negotiated the length of time they stayed engaged. • The case was closed with family arrangement through FGC. • There was clear shared decision-making and contingent planning between the services.	**High collaboration** The case discussions showed collaboration where KWY used the information provided by DCP to plan how to engage the family. The actions did not feel like independent parallel services but rather a partnership. DCP reflected on how their assessment and decision-making would be based on the information KWY provided about engagement. Both organisations discussed how they could support the family, indicating a collaborative stance. KWY and DCP compared their experiences of the family to clarify information.	The children remained living at home in the care of their mother.

		DCP asked for clarification on KWY's risk assessment tool – wanting to know 'risk of what and to whom?' The discussion of the tool led to further considerations of 'what we are seeing and what you are seeing' to compare risk assessment and expertise. In the final case discussions, KWY and DCP discussed how to transition the parents to other services. Little to no information was provided after the final case discussion, with the parents disengaging and the case closing three months later.	
JT Family • 11-month intervention • 5 case discussions • 1 newborn	• The child was removed at birth prior to the KWY referral. • There were long stretches of time between case review discussions. • Victim parent's mental health significantly declined after the child was removed. • Victim parent was constantly ill. • Service delivery was not coordinated. • There was ongoing housing instability with both parents rough sleeping.	**Moderate collaboration** The case discussions provided opportunities to share information. Specifically, these discussions allowed for a better understanding of the relationship dynamics. Some key interventions were derived from these decisions, such as separating the access visits to afford the mother more opportunity to practice her parenting independently. KWY advocated for the rights of the family. They highlighted that historically Aboriginal peoples were	Children removed and placed in long-term care

	• KWY had difficulty consistently engaging the parents. • The decision for long-term orders was made within 6 months without reunification being considered. • Both parents were convinced the child would be returned regardless of feedback about the safety concerns.	forced into compliance. KWY requested that DCP ensure the parents understood all the information and court decisions they were consenting to. The case discussions were held regularly throughout the intervention period but were later than specified by the prototype. There was a transition from assessment orders to long-term orders prior to the second case review discussion. This decision was not communicated to KWY until after the application was already initiated. Further, the case was transferred to another team who did not know the details about the decision. This left both organisations unable to fully explain the decisions to the parents.	
MC Family • 18-month intervention • 4 case discussions • 4 adolescents • 1 young child (2 years) • 1 newborn	• The older children showed violent behaviours. • The Victim parent was pregnant, and the infant was removed during the intervention. • Both parents were closely engaged with KWY. • The parents had a poor relationship with DCP. • There were extended periods of low communication between DCP and KWY with no clear rationale for decisions.	**Low collaboration** Ongoing case review meetings enhanced the communication of DCP and KWY. KWY consistently advocated for culturally responsive practice. Decisions were not made collaboratively. Eventually, DCP changed the orders to reunification	Children reunified with parents after DCP revoked the application for long-term orders

	• There were concerns that some staff had limited cultural understanding. • KWY and DCP questioned whether there was DFV between the parents or just poor relational skills. • There was an ongoing change of DCP and Aboriginal Family Support Service workers. • The initial case direction was for reunification which changed to long-term orders. • After advocacy by the services involved, the application for long-term orders was revoked by DCP.	based on consistent feedback from KWY and other agencies. Subsequent discussions identified KWY attempting to communicate a cultural and trauma-informed lens. DCP staff argued that the mother's behaviours were aggressive and should not be tolerated by their staff. KWY consistently advocated for culturally responsive practice such as support in court and kinship care. KWY and DCP disagreed about the decision to apply for long-term orders. The case review did not clearly document this disagreement and instead KWY was informed in a separate meeting. By the final case discussion, DCP and KWY had improved communication. DCP acknowledged that they had learned how to better communicate with the parents based on KWY's guidance.	
PM Family • 10-month intervention • 2 case discussions	• The initial referral was not from DCP but another agency.	**High collaboration** There was clear, shared decision-making where all voices were heard. The case review discussion	Voluntary kinship placement with child returned to parents

• 1 adolescent	• This was an unusual situation as the child was in a voluntary kinship placement managed by DCP. • DCP wanted to quickly close the case as it could not be held by the team any longer. • The case was a complex intersection of culture and DFV as perpetrator held authority in the community. • The perpetrator encouraged the child to hit the Victim parent. • The victim/mother was highly engaged with KWY. • KWY provided culturally responsive interventions that fit with the Victim parent's needs. • DCP had responsive communication to any risks and worked with KWY to safety plan. • The perpetrator did not engage with any services.	called on all members to ask for their views in the proposed case direction by DCP. KWY provided cultural expertise about the perpetrator's standing in the community, men's business, and family history. Timeframes of the prototype were highlighted when considering how often communication should happen.	
RC Family • 10-month intervention • 3 case discussions • 1 newborn	• The parents self-referred to KWY immediately after their child was removed at birth. • There was coordinated service delivery by all stakeholders with multiple case review meetings. • Both parents were closely engaged with KWY.	**High collaboration** Both services highlighted the high level of communication and collaboration between them. KWY identified that there was regular communication from DCP and that they were heard in the discussions. The services provided were well coordinated and evaluated via numerous review meetings.	Child reunified with parents

SK Family • 10-month intervention • 5 case discussions • 2 young children (2 and 5 years)	• There was a delay to the start of the intervention process due to COVID and December holidays. • After an initial delay, communication was frequent, with regular professionals' meetings scheduled. • The victim/mother was constantly ill. • There was ongoing housing instability with both parents rough sleeping. • KWY had difficulty engaging the parents.	**High collaboration after an initial delay** There were initial delays in the case discussions but later there were consistent meetings. There was clear negotiation about timeframes when supporting the family. KWY provided a rationale for the delayed service provision and queried whether DCP could delay decision making to afford the parents the chance to engage. The final decision for long-term orders was made independently by DCP but KWY offered their agreement in the case review discussion. KWY offered appreciation for DCP's flexibility and innovative thinking.	Children placed in long-term care

Data Collection Methods

To gain evidence on the use of the prototype and therefore collaborative practice between KWY and DCP, three key sources of data were collected for each family.

First, case discussions were audio-recorded and transcribed. The case discussions were organised and chaired by the SLO whereby the prototype provided a structure for DCP and KWY staff to discuss concerns of DFV. In particular, the structure ensured culturally informed practice, visibility of the perpetrator, and child centred discussions. Second the SLO invited families to participate in an interview with the researchers to talk about their experience of working with DCP and KWY. If families agreed, the SLO arranged a time and place that was safe and comfortable for the couple and introduced each party. If all were comfortable, one researcher interviewed the male and the other researcher the female. Interviews took approximately 1 hour. Those interviewed were given a voucher for their time. At the end of the interview, the researchers also sought consent to read their case files, as another layer of data, to ascertain how and if the prototype were shaping practice. Third, a data collection instrument was designed using Research Electronic Data Capture (REDCap) software. REDCap is software designed to manage workflow methodology and collect and store information separate from the original source (Harris et al., 2009). Data was collected from participant case files according to the prototype and uploaded for further analysis.

Data Analysis

To guide the analysis two research questions were posed:

- Did this prototype make a difference to practitioner and families' experiences of collaboration?
- Who is benefiting from the prototype?

Case discussions, and interviews were uploaded into NVivo for analysis. Six case studies were created - one for each family who were the focus of intervention in the KWY and DCP collaboration (see Table 1). The attributes listed were: organisation, cultural identity, presence of intervention orders, relationship status of the parents, placement of the children, and DCP goal for the children (e.g., reunification).

All case discussions and case files were read, creating a vignette of each family. The vignette identified the family history, precipitating incident for DCP involvement, the progress of the family across the case plan, the concerns for the children, and future planning for the family. This process represented the first level of abstraction of the data, allowing for a narrative to be formed. Vignettes were then uploaded into NVivo in their respective cases. Some case files could not be directly uploaded into NVivo, due to their sensitive nature and need to remain onsite with the respective agencies. Instead, a narrative summary was created out of each case file and uploaded into NVivo. Together the documents created a case study database in NVivo, increasing the reliability of the data for additional analysis (Yin, 2018).

The codes from the REDCap data collection instrument were re-created in NVivo to allow dual coding of the data. Case discussions and case files were read, with the data deductively coded in NVivo, creating a segmented database relative to the coding framework. A synthesis of the data was then written into REDCap for the appropriate code. This process represented the second level of abstraction of the data. The dual coding allowed the more abstract syntheses in REDCap to be traced back to the original data, enhancing the validity of the findings, as described by Yin (2018).

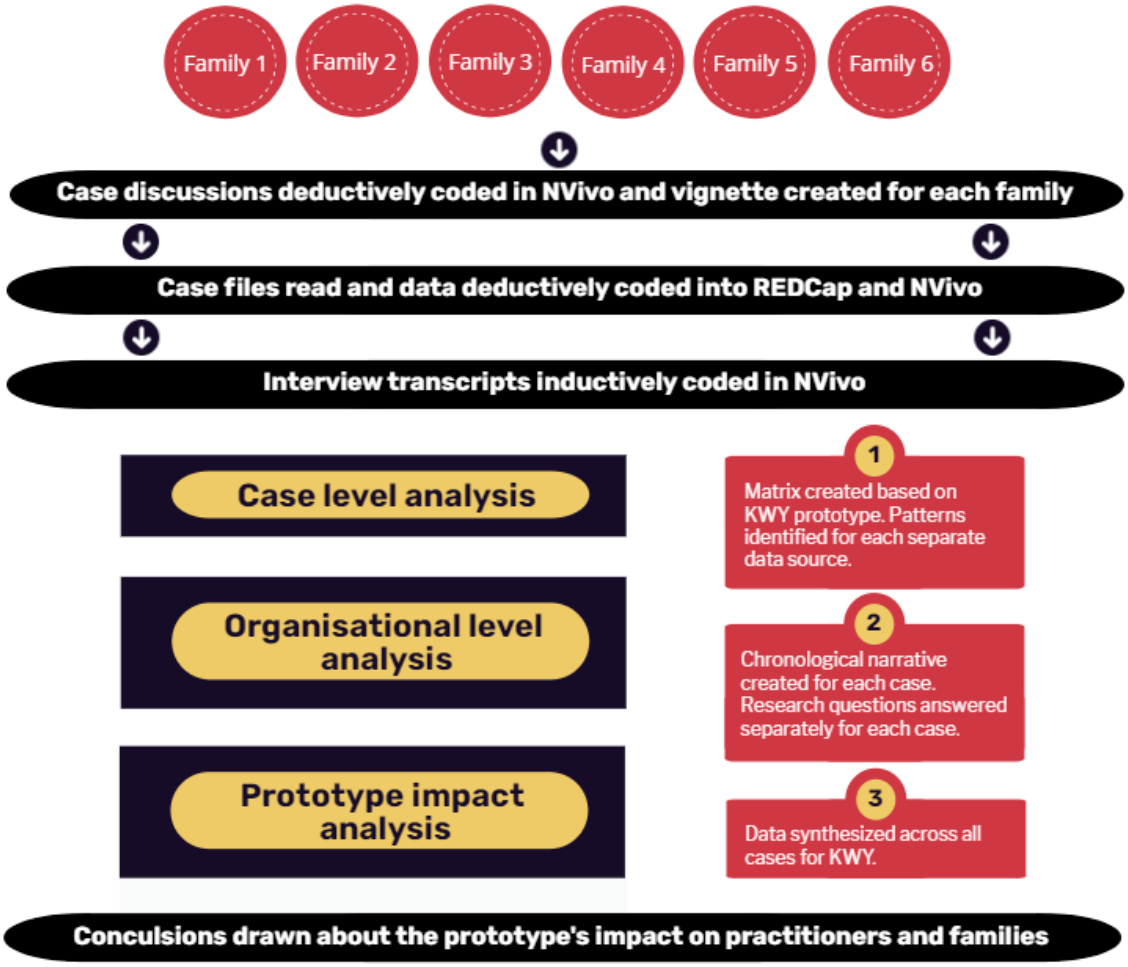
Interviews were then fully analysed in NVivo. Each interview was read, with annotations applied to the data relevant to the research questions. A written memo of thoughts and questions was kept alongside. From this data, a set of preliminary inductive codes were generated. Each interview was then analysed thematically, with additional codes being added as necessary. Once all codes were added, they were clustered into more abstract themes. Once all data sources were analysed separately, a matrix was created which compared each data source for a single case across the three research questions. Based on Yin (2018), predicted patterns were determined that would indicate the prototype was influential. These predicted patterns were placed into the matrix under each research question. The data were then compared to the predictions to determine the impacts of the prototype, any contradictory findings, or new evidence not predicted.

Each case was then written out in both narrative and analysis format. The narrative provided a chronological description of the case, mapped onto the prototype structure. Having the two forms of data alongside each other allowed for better tracing of evidence for conclusions, thus addressing one of the common criticisms of case study evaluations (Yin, 1992). A visual of the influence of the prototype was created that showed the chronological events of the case across the prototype phases (See Appendix One). This allowed for examination of how the prototype influenced the case at significant points. The degree to which the prototype was implemented with fidelity was also mapped onto the chronology, demonstrating adherence to the implementation theory as outlined by Yin (1992). The data for each case was then compared to both the predicted pattern and the level of fidelity to the prototype. This process assisted in triangulation of the data across multiple sources.

The last phase of analysis had all the data from the different cases grouped into the research questions. An inductive, thematic analysis was conducted in NVivo, drawing from all the different data sources (case discussions, interviews, and case files). The full analysis process is shown in Figure 6.

Figure 6

Overview of the Analysis



Given that there were no control cases for comparison, it was not always possible to conclude that the findings were as a result of the prototype. In some instances, participants clearly linked the outcomes to the prototype and appropriate quotes were used as evidence for the findings. In other instances, inferences were drawn about the possible influence of the prototype based on the level of collaboration that occurred in prototype specified interactions (i.e., those not likely to have occurred in the absence of the prototype).

Limitations

The implementation and testing phase of this project was extensive. The final draft of the collaborative service response was completed in November 2019, however, the implementation phase of the collaboration between KWY and DCP commenced slowly. There are several reasons for this delay: 1) funding for the Specialist Liaison Officer from DCP to KWY was delayed thus delaying the recruitment of this position; 2) the Southern Regional hub in KWY did not have capacity to receive new referrals and needed some time to build capacity to accept new referrals; 3) the commencement of the prototype was dependent on receiving referrals from DCP and there was

a delay in these referrals being made, and 4) as referrals were made from DCP to KWY, COVID-19 impacted on progress, which has required some renegotiation of the prototype from both agencies. Thus, full implementation of KWY and DCP collaboration commenced in May 2020.

The operationalisation of the prototypes commenced in early 2020; however, this was at the beginning of COVID-19 and the following occurred:

- KWY was provided funding by DCP to employ an SLO however this did not occur until late 2019 and the employment of a SLO in KWY had taken longer than expected. The position was filled for a short time.
- There was good will and commitment for change across the sectors, however, implementing changes in practice approaches requires a significant investment in time. Working across different organisations required a deliberate and systematic approach to informing staff about the practice change.
- Establishing relationships is the cornerstone of implementation of collaborative service prototypes. An enormous amount of time was invested in building relationships across the agencies and amongst practitioners, particularly where there has been a history of diminished level of trust. This lack of trust has hampered progress in some areas and needs to be worked through safely and slowly.
- DCP had spent considerable time in the development of a domestic and family violence practice paper, however, this paper had not been fully implemented during the prototype development. Working across two organisations, where one of them was not domestic and family violence informed, necessitated greater investment. Increased time and communication were needed to ensure there was respect for each organisation's expertise and cultural knowledge. The project supported the development of a domestic and family violence informed culture through processes such as the working groups and case discussions.
- Due to the delays in the implementation of the prototypes, there was a delay in the recruitment of families. Recruiting families requires stability in the trialling of the prototype.
- Agencies needed time to develop safety and wellbeing protocols for staff and clients in terms of COVID 19. Work practices in both organisations altered in response to the need for social distancing. The altered work practices, such as reduced face-to-face contact and increased telephone counselling was not reflective of the practice outlined in the prototypes. COVID 19 meant we could not trial and test the prototype in 'normal' conditions and the operationalisation of the prototype could not occur as initially planned. In addition, we could not progress recruitment of families into the project. Under the changed conditions, the full capacity of the SLO positions had not been fully implemented.

Full operationalisation of the collaborative model occurred when COVID restrictions were lifted in May 2020. Once this occurred, a systematic approach was implemented to ensure that staff in KWY and DCP offices in Noarlunga and St. Mary's were re-orientated to the model. Research and leadership staff met with operational staff to explain the service model and processes involved for their implementation. These information sessions occurred at various points of the implementation process as there was a high staff turnover in DCP and a change

of leadership staff during the implementation process. Information sheets were also distributed throughout the organisations to ensure all staff were informed and take advantage of learnings that emerged from the project.

Another limitation relates to the data available. Conclusions about the level of communication between the organisations were drawn from the case discussions and case files. Any instances where communication was not documented could not be analysed. Further, only KWY case files were analysed, and therefore additional information on collaboration stored in DCP files may not have been included. This could contain data such as decisions made in DCP meetings for how to collaborate with KWY or attempted but unsuccessful phone calls. If this data was available, it may have shown a more nuanced relationship between the two agencies than could be concluded from the available data.

Findings

Themes arose from the analysis of case discussions, interviews with families, and reading of case files. The themes presented below are structured to enable presentation of evidence regarding the two research questions:

- Did the prototype make a difference to workers and families' experiences of collaboration?
- Who is benefiting from the prototype?

The themes presenting the experience of using the prototype to enable collaboration between KWY and DCP are presented first, followed by the themes that enable insight into how the prototype benefited practitioners but more importantly, the families.

Demographic Information

Cultural Background

All of the victim parents in the case study identified as Aboriginal, however, only two of the perpetrators also identified as Aboriginal. The remaining perpetrators identified as non-Indigenous. Most of the victim parents felt disconnected from their culture, and one did not know that she was Aboriginal until DCP conducted a genogram.

Information about the Children

The family size varied from a single child to large sibling groups of up to six children. In four cases, one of the parents had at least one older child who had child protection involvement or was being cared for by relatives. Blended families were common, and only one case had all children born to the same two parents.

The age range of the children extended from birth to adolescence. In all except one case, there were children under the age of five years. In two cases, the children were removed at birth prior to the intervention, and, in another case, the mother gave birth to a child who was removed during the intervention. For these children, the intervention period overlapped with significant developmental milestones. At the close of the intervention period, the three newborn children were 9 months old, 11 months old, and 18 months old, respectively. Two of these children were reunified with their parents while the third was placed on a long-term guardianship order. In cases

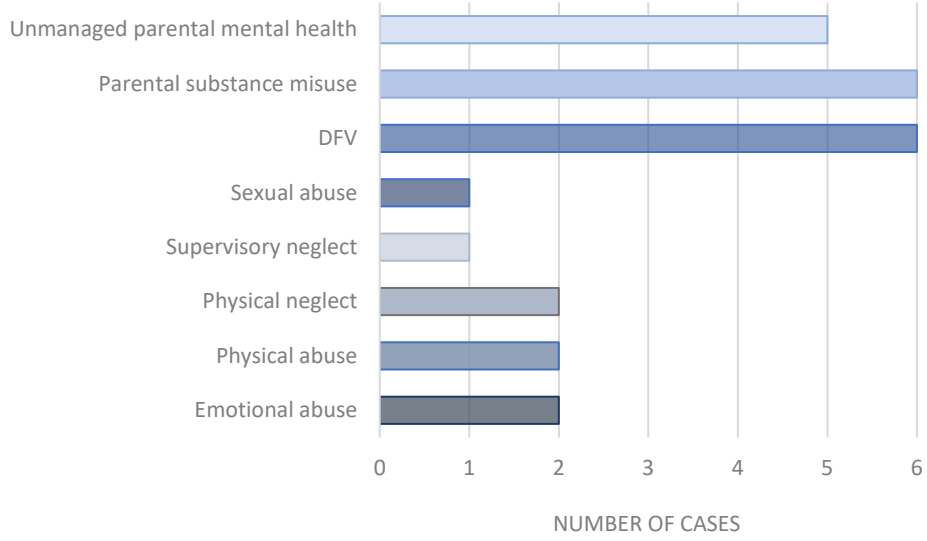
with diverse sibling age ranges, the behaviours of the older children were also identified as risk factors to the younger children. These behaviours typically involved aggression and substance misuse.

Child Maltreatment Types and Impacts

All the children had DFV and parental substance misuse identified as a maltreatment type, with all but one family having unmanaged mental health as a concern. Emotional abuse and physical neglect were the next most common identified (29%). No concerns of emotional neglect were identified for any of the families. Often concerns for children were inferred rather than clearly discussed, such as stating that the parents misused illicit substances, but not indicating the specific risks to the child. The identified types of maltreatment are shown in Figure 7.

Figure 7

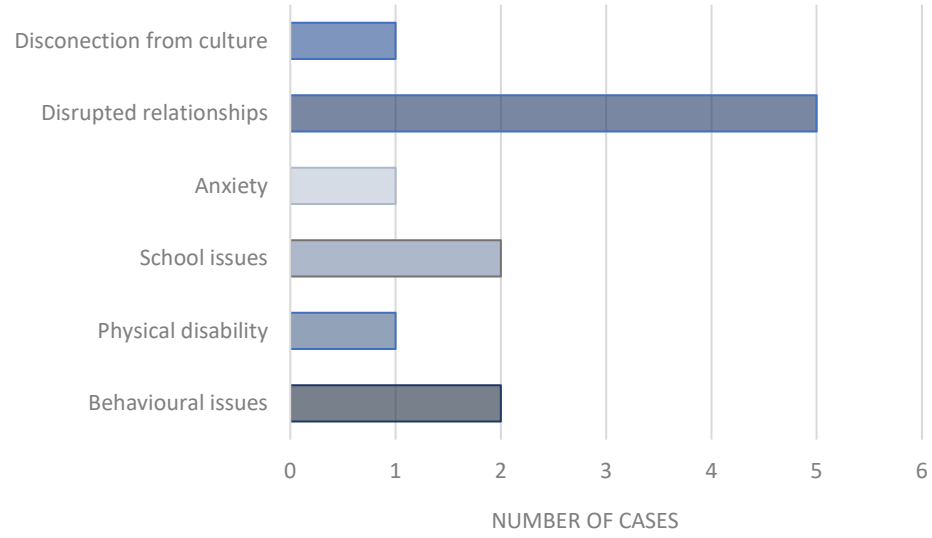
Children's Experiences of Maltreatment



In most of the families (83%) the child/ren had been removed from the care of their parents for a period of time, disrupting their familial relationships. In both the JT Family and the RC Family, the removal occurred at birth and was the only impact identified for the children. In families with older children, greater impacts were identified. The most common were poor school attendance and behavioural issues. The range of impacts experienced by children are shown in Figure 8.

Figure 8

The Impacts of Trauma on Children

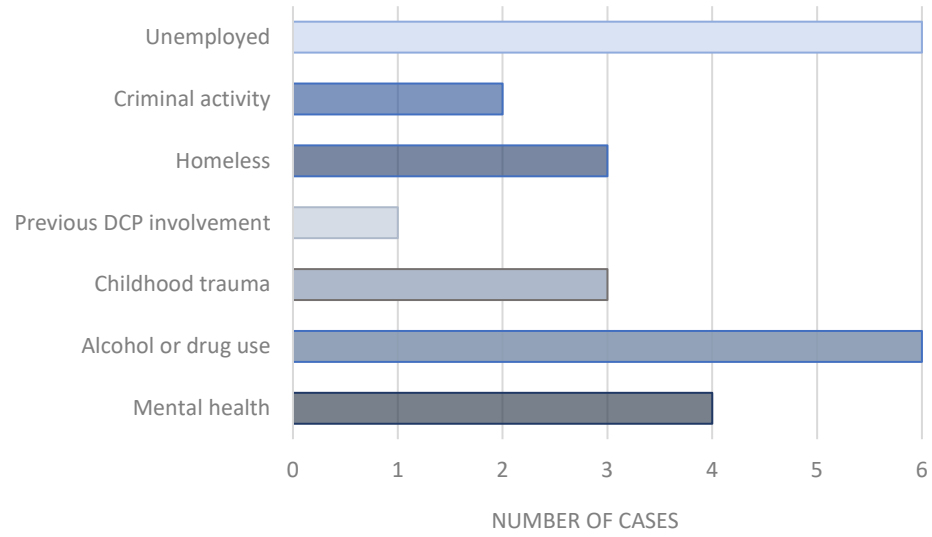


Perpetrator Complexity

Perpetrator characteristics were identified that contributed to complexity. All perpetrators misused drugs or alcohol and were unemployed. Mental health issues were prevalent, with four perpetrators identifying concerns with their mental health. Of those, three identified childhood trauma as a contributing reason to their poor mental health. All perpetrators had three or more complexities, with the SK perpetrator having the highest number (7). The different experiences of the perpetrator are show in Figure 9.

Figure 9

The Experiences of the Perpetrator

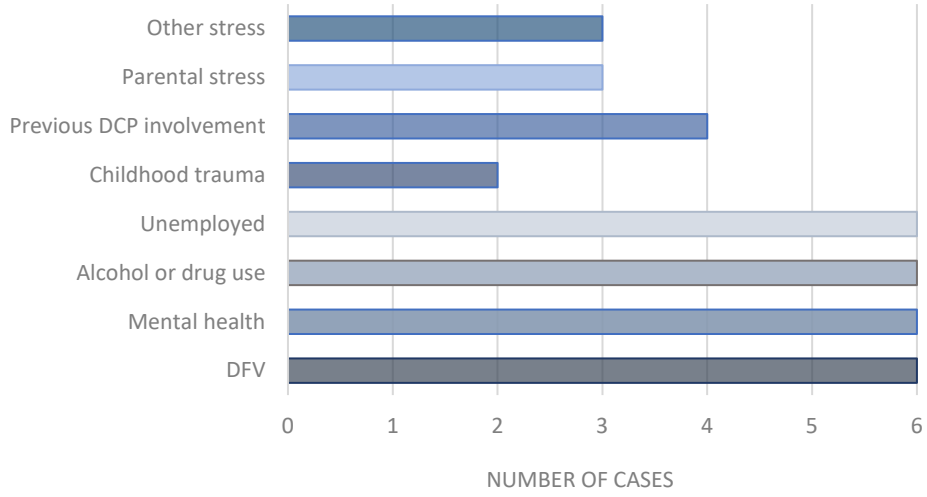


Victim parent Complexity

All the victim parents experienced concerns with their mental health and used alcohol or drugs. Three of the victim parents had previous involvement with DCP and felt parental stress managing their children. Three of the victim parents lacked stable housing. All victim parent identified at least six complexities, with the PM victim parent having the most (8). The experiences of the victim parent are shown in Figure 10.

Figure 10

The Experiences of the Victim Parent



Intake, Case Discussions, and Warm Referral

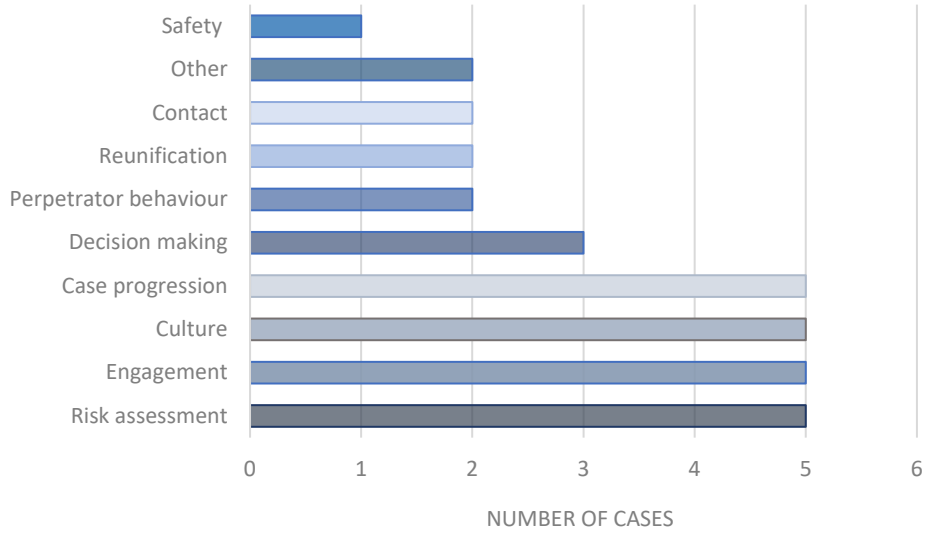
The length of time from the referral to the first case discussion varied. All cases discussions took over 30 days to be scheduled, with the exception of the JT Family where the case discussion was scheduled just nine days after the referral. Most warm referrals occurred quickly after the initial case discussion, with two of the cases meeting the family the next day and another within six days. Two of the families had longer periods between the discussion and warm referral, at 30 and 55 days delay respectively. In one case, there was no warm referral as KWY had already met with the family. In another case, DCP did not make the referral, and KWY informed DCP to initiate the prototype.

The case discussions were well attended, with most having the KWY men's worker, KWY women's worker, SLO, DCP case worker, DCP supervisor, and DCP Principal Aboriginal Consultant. All cases had more than one case discussion, indicating that DCP and KWY both remained involved to manage the risk and complexity. The BA Family, JT Family, and SK Family each had four case discussions, representing the highest number.

The content of the case discussions was coded against the structure of the prototype. Almost every family (83%) had risk assessment, engagement, cultural connection, and case progression as a topic during the case review discussions. The least discussed aspect in the case discussions was safety, likely reflecting that many of the children were in placements where they were deemed safe. The full range of themes is shown in Figure 11.

Figure 11

The Content of the Case Review Discussions



There was a lack of child-focused conversation in the case discussions. Younger children (age five and under) were all in foster or kinship care and, unless they showed significant behavioural or developmental issues, they were rarely part of discussions about risk or safety. Older children were more prominent in the case discussions, however, the topic often quickly shifted to parenting rather than considering the experiences of the children. Children's experiences were also usually framed in terms of adult behaviours, rather than the impacts of those behaviours on the children. For example, the victim/mother might be described as "emotionally unstable" yet there was no discussion on how this instability might affect the children in her care. This adult focused discussion was more likely due to KWY not having a children's worker during many of the interventions.

Intervention Period

Of the six cases, three had a 10-month intervention period. The longest intervention period was 18-months. There was no relationship between the length of the intervention period and the level of collaboration, although the longest intervention also had the lowest collaboration. This case continued because of the deeply opposing views of DCP and KWY, regarding reunification. There was also no relationship between the length of the intervention and the outcome for the children. Both cases where the children remained at home demonstrated high collaboration. One of the reunification outcomes showed high collaboration, however, as mentioned above, the other reunification outcome resulted from ongoing tension and low collaboration.

All victim parents were offered individual counselling and group counselling as an intervention. All perpetrators were offered individual counselling and group counselling as an intervention, however, only two of the perpetrators engaged consistently. Multiple referrals were provided to address mental health, physical health, and alcohol and other drug counselling. Every victim parent received at least one external referral. Every perpetrator, with the exception of the BA Family perpetrator, received at least one external referral.

Of the six cases, two were closed due to DCP seeking long-term orders, one due to non-engagement/non-eligibility, and three due to the case goals being reached.

Communication

The communication between DCP and KWY outside of the case discussions was analysed. In all cases, communication addressed case progress. Three cases communicated about problem-solving, and two about the engagement of the family. Only one case communicated about risk assessment and one about plans for intervention. Most communication occurred during the case discussions or other scheduled professional meetings. The different purposes of the communication between DCP and KWY are shown in Figure 12.

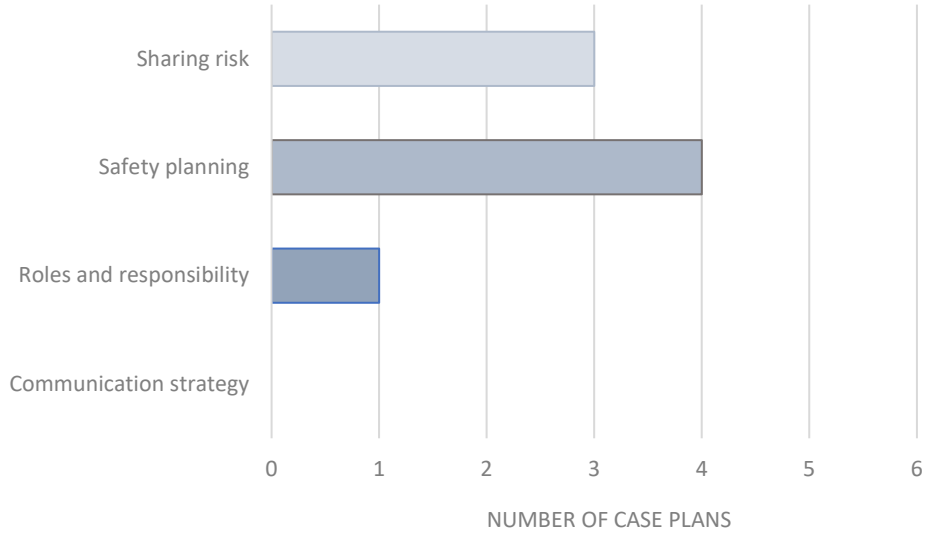
Figure 12

The Purpose of Communication Between KWY and DCP

The shared case plans of the prototype were used to summarise discussions and create actions for the next meeting. Each organisation continued to maintain their own case plans that related to case direction and were used for work with the families. The shared case plans most often focused on safety planning and sharing risk. No case plans recorded communication strategies between KWY and DCP. The contents of the shared case plans are shown in Figure 13.

Figure 13

The Content of the Shared Case Plans



Practitioner Experience

This section identifies the themes associated with practitioners' experience of the prototype and its impact on their collaboration. To achieve collaborative communication, practitioners found that they first needed to establish a shared language around core concepts. They also needed to use the prototype case discussions as a space to build relationships and challenge preconceived ideas, allowing for innovative and critical thinking. The prototype readily increased information sharing, allowing perspectives to be compared. This was important to avoid organisations unintentionally working at cross purposes because of absent or unclear communication. However, there were challenges to sharing written information, such as case plans. Shared decision-making was difficult to achieve, and instead a consultative approach developed. Practitioners discussed their respective organisational processes, which clarified their roles and their capacity to address the complexity experienced by families. Finally, space was given to practitioners to share their expertise and advocate for the victim parents, children, and share insights into the perpetrator's behaviour. Each of these key factors, outlined in Figure 1 below, are discussed next, in detail.

Figure 14

Summary of the Key Factors Associated with Practitioner Experiences

Collaborative Communication

Communication was foundational in forming collaborative practice. When examining the data, there were two levels that influenced collaboration: the content of communication and the process by which practitioners communicated. Without both levels being addressed simultaneously, tension and misunderstandings could develop.

First, practitioners identified that the content of their communication needed to generate shared understanding to be effective. The prototype workshops highlighted that language was used in different ways and did not always convey the same meaning. In order to develop a truly shared understanding, practitioners discussed their use of professional language to clarify concepts such as risk, safety, domestic and family violence, culture and gender. Without this shared understanding, the meaning of their communication could be misinterpreted or lost.

The most notable concept that raised debate was the meaning of risk and what constituted different risk thresholds. It was difficult to hold a shared understanding of risk as the values, beliefs, culture, and norms of individual practitioners influenced the meaning they held. This resulted in disparate interpretations of risk in the context of DFV on both an individual and organisational level. Practitioners identified that their own organisations may not have clearly defined risk thresholds:

> *[Something] we really need to do for true collaboration is have that common understanding of risk and safety, like when has the threshold been hit and actually it needs to come back to DCP … different agencies have different thresholds. You ask us to name our threshold, we probably can't do it.* (KWY co-design workshop 1)

The co-design process of the prototype directly supported practitioners to develop a joint understanding of important concepts, such as DFV, risk, or cultural safety, by setting aside space for the co-construction of meaning. Within this space, practitioners discussed those concepts and developed a shared professional language to facilitate future communication. The data showed that this was not a single event, but an iterative process brought up repeatedly in subsequent case discussions. One KWY staff member reflected on the process of establishing definitions of DFV concepts:

> *You'd have to work it out [by doing] pieces of work along the way … What is this actually looking like? What does it mean? How does it work in the context of our collaboration?* (KWY co-design workshop 2)

Throughout the case discussions, information was also shared about organisational policies and processes that influenced service delivery, for example this discussion about parenting capacity assessments:

> *KWY: So, have you asked the question whether they have capacity to parent? Is that one of the questions …?*
>
> *DCP: Yeah, what their capacity is like. Would it be a full-time parent, are they you know, able to meet the needs or would it be more of a … you know, where are their supports needed for them to be able to meet that? … they'll tell us everything from that assessment … And sometimes parenting capacity can give us like a timeframe, like it'll take about 12 months for them to work on this, this and this and then so that can be helpful as well.* (MC Family, Case review discussion 1)

In the above quote, KWY practitioners gained an understanding of the parenting capacity assessment, a core component influencing DCP's decision-making. The concept of 'parenting capacity' was now embedded within a specific assessment that was provided to DCP, rather than different practitioners having different interpretations. Holding a better understanding of different organisational processes helped to build future collaboration. Practitioners were provided context for why certain decisions were made or why certain timeframes were set, which might otherwise seem arbitrary or confusing.

Collaborative communication was directly facilitated by the prototype. One of the structured components of the case discussion asked the organisations to reflect on their communication and highlight any issues. In the SK Family, KWY and DCP spoke openly about the importance of gaining holistic information about a family to ensure they were not working at cross purposes:

> *SLO: Communication preference – how's the communication going with us? With KWY.*
>
> *DCP: … when I've sought communication from [names staff], they've both responded I guess to any questions I've had, and I've clarified … So just I guess clarifying that with KWY, because I think there has been a bit of them [parents] stating to KWY one thing. And then to me other things. So, I guess really having that open communication where we know exactly what we are working with – with the family as well.*

SLO: Yeah, we're going to have to keep yeah that communication lines open, and quite tight, because the last thing I want is these parents telling us lies pretty much. It's not going to go down well with our program. (SK Family, Case review discussion 1)

By communicating directly, organisations avoided the family members becoming the conduits of information.

The second level of communication involved examining the process, or way in which practitioners communicated. Here, the concept of relationship building was central. Practitioners demonstrated respectful communication while also challenging each other's viewpoints. This allowed for more robust conversations that addressed critical and sensitive issues for families. This was important as KWY staff identified that *"[professionals] think inclusion is collaboration and it's not*" (KWY co-design workshop 1). Rather than only being included, KWY staff wanted to have a voice, where their expertise was valued even if it challenged DCP views. Genuine collaboration resulted in both organisations having meaningful input into decision-making and case directions.

One way in which relationship building was most facilitated was by having a Specialist Liaison Officer (SLO). The SLO served as key person across both agencies who nurtured relationships and facilitated open, transparent, and clear communication. The co-location of the SLO, who could create a bridge between stakeholders, allowed for faster, more informal, and explorative discussions. The human connection provided additional benefits such as facilitating trust, mentoring staff, broadening perspectives, exploring values, and generating critical thinking.

Overall, collaboration on both the content and process levels generated ongoing communication that created a shared understanding of a family. This was important to facilitate accurate risk assessment and service provision. Throughout the intervention period, risk levels fluctuated as new information came to light, and as families progressed towards safety or had critical events influence their capacity to cope. In order to remain collaborative, communication had to be responsive to the family's needs, with both organisations proactively seeking each other's input.

Holistic Information Sharing

Information sharing was the predominant feature of the prototype case discussions. Updates were provided at each case discussion focusing on matters such as assessments, drug screens, access visits, and parental engagement. These updates allowed the two organisations to align their service delivery.

The case discussions also provided opportunities to ensure an accurate picture of the family and associated risk were being perceived by both services. KWY and DCP compared their experiences to clarify information and support contingent decision making. For example, DCP and KWY initially had different views about the BA family's progress until DCP shared the results of a recent drug screen:

DCP: So, [mother's] drug screen was positive. [Father's] was clean.

KWY: Okay. That's interesting.

> *DCP: And he has had quite a few clean drug screens, hasn't he? [Father] admitted that when he came out of prison he was going around there, and they were using together ... So, the drug use has been going on since before [father] came out of prison. And mum said to one of the kids – well, one of the kids overheard her, and mum said, well if DCP drug screen me, I'm just going to say that I'm using because I'm stressed because [father is] coming out of prison.*
>
> *KWY: Right. So, she's playing us.* (BA Family, Case review discussion 2)

The combined information formed a holistic picture of the family in relation to risk and safety. This allowed DCP and KWY to ensure their service delivery was collaborative and perceived as unified by the family. It also avoided situations where the family may present different information to the different organisations in order to influence perceptions.

An important aspect of this information sharing was highlighting the behaviour of the perpetrator. This was a key element of the prototype and was present in almost every case discussion. When discussing the perpetrator, patterns of violence were identified and recorded as well as the contextual factors that influenced violence, such as alcohol use or mental health. Both KWY and DCP provided a nuanced analysis of the underlying dynamics, such as by noting the non-verbal behaviours of the victim parent when in the presence of the perpetrator. The impacts of violence on the victim parent were less prominent in the discussions, although they were still highlighted. The prototype prescribed a separate agenda item to discuss the impacts on the victim parent, however, this did not often occur. Instead, the impacts were often considered in response to other information presented, rather than as a delineated discussion. The children were even less visible. Updates on the children primarily focused on either their placement or observations during contact visits. Few symptoms of trauma were identified and instead conversations focused on general wellbeing. A contributing factor may have been the young age of many of the children involved and their placement in out-of-home care where they were deemed safe.

The frequency of communication also influenced information sharing. Up-to-date information could generate contingent decision-making and accurate service delivery. In the case with the most successful communication, meetings were scheduled every three weeks. KWY noted the positive nature of these frequent meetings stating, "*Communication with this family with DCP and us has been amazing, and that has been a really big positive impact on this family progressing*" (RC Family, Case discussion 2).

However, there were still some examples of important information not being shared. In some instances, DCP had not updated KWY on significant changes to cases, such as where the children were placed, or whether the parents had mandated drug screening scheduled. In these examples, information sharing appeared to be delayed and impacted KWY's service delivery:

> *DCP: So, was she telling you that she was going to the drug screens when he was incarcerated, or you knew that she wasn't?*

> *KWY: I wasn't aware she had the drug screens. I didn't know about scheduled ones. That actually might be something if we could be made aware.* (BA Family, Case discussion 2)

Sometimes there were specific barriers to collaborative information sharing. In one case, DCP felt that KWY was "*being unreasonable*" with their information requests. DCP further stated that future communication would occur through the parents or legal team rather than through the social worker:

> *DCP: But definitely I think over the last couple of weeks I do need to say there has been multiple emails from both [names KWY staff] around wanting this document, that document, this document – well we can't just produce documents out of the children's file willy nilly either – I am not saying it's all willy nilly but definitely with the parents – like the email that I sent back to you yesterday – the parents like she said she wants ABCD and E – she will get a copy of these documents with her court application and stuff like that. So, we can't just keep giving her documents.* (MC Family, Case discussion 2)

In this case, both KWY practitioners and the parents expressed frustration with the lack of communication from DCP. KWY attempted to explain that the parents were trying to prepare for court and felt overwhelmed, but DCP remained focused on communicating via legal channels.

The shared case plans were meant to be a source of holistic information about families; however, these were not always used as the prototype intended. Typically, the 'shared case plans' were used as meeting minutes, reflecting the case review discussion. While they sometimes contained shared actions, this was not consistent across the different cases. Additionally, each organisation kept its own internal case plan, meaning that the 'shared case plans' were not a primary document. Instead, KWY and DCP shared their internal case plans with each other, resulting in duplication and additional paperwork. KWY reflected on the challenge of holding shared information with DCP:

> *Just working in silos a little bit in terms of sharing information. It's a little bit inconsistent in terms of us asking for information and getting different results from different supervisors.* (DCP and KWY working group)

Overall, the prototype highlighted challenges to information sharing. While there were frequent case discussions, there was limited information to suggest that communication continued outside of the discussions. Even when the case discussions were consistent, the quality of interaction depended on staff availability. Some members had to leave early, others complained about the length of the discussions, and not all members could attend every discussion. This often resulted in the start of case discussions repeating the facts of the case rather than furthering the conversation to a solutions-focused space. Additionally, the latter components of the case discussion agenda were less likely to be used, as they were not able to be discussed in the time allocated. This meant that information sharing was still limited by competing priorities and time-poor staff.

Challenges to Shared Decision-making

The data show that shared decision-making was difficult to achieve. Most cases demonstrated a pattern where DCP made a decision and then informed KWY at a subsequent case review discussion. Frequently, it was still unclear why some decisions had been made and, at times, even DCP staff did not know the full rationale behind a decision. For example, in the JT Family, the primary decision was to apply for a long-term order, which was granted six months after the initial referral. There was no recorded information to indicate how the decision was made and whether KWY shared in the decision-making process. In the second case review discussion for the family, DCP provided an update on the child's placement, indicating it would be long-term. The discussion demonstrates that KWY was not aware of the long-term orders being sought:

> *KWY: Can I ask a question? Is there a plan for reunification for this family, for the child to-?*
>
> *DCP: No, cos the application was made for long term orders when it came over to my team, so they'd already made an application so it's currently going through court …*
>
> *KWY: So, what was the reunification plan?*
>
> *DCP: I don't think there was one … My understanding was it went from a 3-month order to straight long term.* (JT Family, Case discussion 2)

There was no further discussion about the reasons for the decision or whether KWY was aware prior to the meeting. The first mention of long-term orders in KWY case notes was when the victim parent told her KWY worker about the order. This occurred one-and-a-half months prior to the case review discussion. It appears that this information was shared via the parents rather than between KWY and DCP staff. Other cases demonstrated a similar pattern of decisions being communicated via the parents.

Another factor affecting shared decision making was that DCP staff with decision-making authority were not present in the case discussions. While DCP case workers, supervisors, and senior practitioners attended the case review discussions, decisions were still made by higher-level DCP staff, disconnected from the prototype. This meant KWY could be consulted before or advised after a decision, but it was not possible, within the current prototype design, for decisions to be fully collaborative. Although KWY was generally in agreeance with DCP's case direction, there were some instances of disagreement. The most prominent example of this was in the MC Family, when a decision for long-term orders was made by DCP while KWY still considered reunification viable. The case file noted:

- *DCP have advised that they are applying for a long-term Care & Protection Order (18 years)*
- *The parents do not know that DCP will be applying for this*
- *KWY are still able to present our case to support the family at court, to map the progress for the family*
- *KWY can advocate and recommend DCP apply for 12-month reunification order instead*.

The decision to obtain long-term orders appeared to be weighted heavily towards the recommendation of the parenting capacity assessment conducted by Child Protection Services within SA Health. KWY requested to see the parenting capacity assessment, but DCP stated they could not provide it and that KWY should obtain a copy from the parents. In this case, DCP had informed KWY about their decision before either KWY or the parents had an opportunity to review the information in the parenting capacity assessment. The following was recorded by KWY case notes:

- *DCP have advised that they will be planning to tell the parents at a meeting, with KWY to attend, that they will be applying for Long-term orders when the current order expires.*
- *Copy of the Parenting Capacity Assessment will not be provided to KWY, this is up to the family to share.*

These interactions demonstrate that even when there was communication, it did not always result in the sharing of information or collaboration.

Other cases showed higher levels of collaboration. KWY worked collaboratively with DCP to offer ongoing information and service delivery to sustain the case direction. Where case closure was considered, or reunification planned, KWY provided ongoing risk assessment. For example, in the case of the PM Family, several incidents occurred within the family which increased their risk level. The perpetrator was violent and regularly intoxicated within the home. The young person (son) was not consistently going to school or treating his health condition with medication. KWY was able to safety plan and liaise with DCP, resulting in case closure as KWY could mitigate the risk through intervention.

There was also evidence of contingent decision making. At times, DCP actively sought KWY's input prior to DCP finalising the case direction, however, this appeared to be at the discretion of the individual DCP staff member. For example, with the SK Family, KWY advocated for more time to engage the parents. The case file noted that DCP were:

> *… waiting until end of May 2021 to give the parents the opportunity to make a meaningful effort after having the discussion on 30 April and 03 May 2021 that the Department are going to reconsider case direction, i.e. make long term plans for the girls if they are not able to demonstrate meaningful engagement with services, attendance at drug screens and family contact.* (SK Family, Case file)

Following this discussion, KWY attempted to re-engage the parents and updated DCP on their progress. In case review discussion four, DCP then advised that the decision had been made to progress to long-term orders. KWY concurred, given that they were unsuccessful engaging the parents. Although KWY was not included in the decision-making, the prior consultation meant that their views were given a voice within DCP.

Having this voice was important to KWY who actively expressed their desire to participate in decision-making. In some cases, KWY started the case discussions by highlighting the purpose of the prototype. This included

identifying the historical challenges both organisations faced in their collaborative practice and the goal of changing those interaction patterns:

> *The purpose of these case discussions is that we share information openly and then, when we come to decision points, we make those together, as a collective. That's part of the model. I know DCP, in the past, have normally driven a lot of the decision-making process. This project is about watering that down and that we all take responsibility for this family and the decision making.* (PM Family, Case discussion 1)

To achieve this participation, KWY consistently presented their risk assessment and stage of change as part of their information sharing. Despite their involvement, they still expressed frustration that they felt "*not trusted*" and had "*no weight in assessment*" (KWY and DCP working group). Again, this often depended on the individual DCP practitioner, and fluctuated with staff turnover.

Overall, there were no cases that demonstrated shared decision making. Some DCP key decision makers did not attend the case review discussions and therefore decision making sat outside of the prototype. Some DCP staff worked to create contingent decision making, where KWY was provided an opportunity to have input prior to decision making. This resulted in KWY having influence and established some foundational collaboration.

Barriers to Addressing Complexity

The data showed that often cases were closed when the immediate risks had abated, yet all families had complex risk factors that affected their capacity to sustain change. The case discussions provided a space to review this complexity and sometimes altered initial decision-making so that risk was shared. For example, in the BA Family, a KWY senior practitioner instructed KWY staff to close the case after the next case discussion with DCP. However, DCP provided additional information that highlighted why they wanted KWY to remain involved. After a discussion, KWY and DCP decided to continue joint service delivery. After this decision, there was significant chaos experienced by the family. Within the three months prior to case closure, the victim parent stated she was using methamphetamines several times per week, her daughter sought an intervention order against an ex-partner, and the perpetrator's house was burgled. The victim parent accused the perpetrator of threatening her and lying to services about his drug use. Both parents resumed their relationship stating they did not need any support from either KWY or DCP as they had stopped taking drugs.

During this time, there was decreased collaboration between KWY and DCP, with no case discussions or instances of communication recorded. The victim parent no longer responded to KWY visits or phone calls. Despite the ongoing chaos, the case was closed with a family group conference. KWY's case file stated:

- DCP stated that once this [family group conference] agreement was in place, they would be closing the families' case file- with no intention to seek any Guardianship Orders.
- KWY did not have intensive engagement from the family, and so advised KWY service file will also be closed pending FCG agreement being developed.

The BA Family were not the only ones to experience ongoing chaos around case closure. In the PM Family, DCP continued towards case closure despite the perpetrator being found intoxicated at the home and there being SAPOL involved DFV incidents. DCP based this decision on KWY safety planning with the family and there being few legal options for DCP to pursue. At the time of case closure by both KWY and DCP, the child spoke of being depressed but there was no indication that his needs had been addressed. Case closure was based on a reduction of the DFV, which is the eligibility requirement for KWY service delivery:

> *[Mother] was exited from KWY service due to being in the SSFH program for over 6 months, DV had reduced, DCP had closed the families' case, and the family were connected to long-term supports.* (PM Family, Case file)

On closing, KWY identified cannabis use, an unhygienic household, mental health, and stable housing as unmet needs of the family. The case file for the child contained no data on his assessment needs or case closure rationale.

The decision to close a case was also influenced by systemic pressures, such as waitlists. KWY had to consider families yet to receive a service, which influenced the length of support they could offer to families currently in their program. KWY explained:

> *Our program is funded for 5 families; we've got 16 at the moment … we're turning down referrals.* (SK Family, Case discussion 3)

KWY also had eligibility criteria for the SSFH program that influenced case closure. The service model was not designed to go over six months, and this was often identified as a reason for case closure in the file. Further, if the parents separated, or DFV abated, cases were closed even if there were ongoing issues affecting the family. The service mandates of both DCP and KWY may therefore have been insufficient to address the complexity of families where DFV was one component of a set of interrelated issues. It is acknowledged, however, that KWY maintains a range of services, and service may have continued for families in other programs, such as in therapeutic group sessions or mental health counselling. This information would not have always been evident in the data analysed.

The complexity faced by families also impacted permanency decisions. The parents queried whether the timeframes DCP placed on them were realistic and highlighted the complexity of issues they faced. During interviews, the parents explained that they needed time to heal and change their behaviour. For example, the perpetrator in the JT family spoke about trying to change his lifestyle:

> *… three months is nowhere near enough for someone who is a blown heroin addict or whatever or hot head to get off all of that and turn their whole life around backwards, and be in a stable kind of lifestyle* (JT Family, Male interview)

At other times, the decisions made by DCP seemed sudden and contradictory to the family experience. The parents in the MC Family were confused by the decision for long-term orders as they felt they were making adequate changes:

> *… just all of sudden we went to go for the review sort of meeting and what was going to happen in court after they had been telling us everything is going great, keep up the good work guys. We are looking at reunification, so we are really excited about it, and we went to the meeting and just all of a sudden without expecting it all, they have gone 18-year order.* (MC Family, Female interview)

An additional complication was that decision-making timeframes did not always align with service-delivery timeframes. The data showed that collaboration often took time to develop, and initial meetings with the families could be delayed. In the BA Family, four weeks had passed before a warm referral was completed after the initial case referral discussion. In fact, the perpetrator was released and re-incarcerated before the first case review discussion took place. In the JT Family, two-and-a-half months passed between case discussions, yet the initial assessment order was only for three months. This meant that the decision for long-term orders was made without a recent case review discussion. For the MC Family, there was a gap of five-and-a-half-months between the first and second discussion, during which the mother gave birth, and the child was removed.

KWY noted the challenges faced by families and were willing to advocate when timeframes did not align with service delivery or fairness to the family. For example, in the SK Family, there were significant delays to engaging the family which impacted on their ability to progress in the case plan goals:

> *KWY: I'm just wondering what your thoughts would be on I guess advocating in that space for that time frame, so you'd push back a little bit? Just in terms of when KWY actually started working with the family, was a significant time from when the referral was actually made … there was that COVID lockdown … waiting for a warm referral with DCP initially. But because the workers changed internally a few times, it was a bit problematic, and hard to tee up … I don't think it would be fair on the family, because they haven't had that support – our supports in place for that whole 4-month period, because we weren't working with them, if that makes sense?* (SK Family, Case Discussion 1)

In the above case, DCP re-adjusted the timeframes, allowing more time for KWY to engage the family. The subsequent frequency of meetings for this case were exemplary and highly collaborative. However, for most of the cases analysed, the ongoing delays in referrals, waitlists for services, and rescheduled meetings juxtaposed the tight timeframes for decision-making. Cases were slow to start, quick to close, and decisions often made between meetings rather than as an outcome of collaboration.

Bringing Together Expertise

One of the objectives of the prototype was to bring together the expertise of staff from both organisations to better inform decision making and service delivery. Throughout the cases analysed, both DCP and KWY brought their respective expertise to case discussions.

KWY held specialist DFV and cultural expertise. There were several instances where they advocated for families using a cultural lens. For example, in the JT Family, KWY questioned whether the parents' cognitive capacity was sufficient for them to understand that they were consenting to long-term orders. KWY further advocated for culturally responsive practice with the JT Family explaining that there was deep distrust by Aboriginal peoples towards government departments:

> *… from an Aboriginal perspective, what I get worried about is that you know everything's explored within this to make it fair, you know I mean that's what I just get concerned over.* (JT Family, Case review discussion 4)

In response, DCP argued that the parents had legal representation, and therefore consenting to long-term orders was procedurally fair:

> *I do agree, I guess the other side to it is that the parents were afforded legal representation, so you know I think, my thoughts around that would be extremely different if we had these concerns, and they didn't seek legal representation and they just consented.* (JT Family, Case review discussion 4)

In this case, as with the MC Family, legal knowledge and authority took precedence over other forms of expertise. DCP staff often referred to their legal directorate, family lawyers, or Crown Law as holding this authority, which limited their collaboration with both KWY and the families. Although lawyers were not present in the case discussions, legal expertise and statutory authority remained an ever-present concept:

> *DCP: I am not telling you [KWY] how to do things, but the best way – the legal stuff needs to be managed with a lawyer, whether you go to a legal appointment with her and then explain what the lawyer said if she doesn't understand that, but they're the legal experts.* (MC Family, Case discussion 2)

Expertise was also shared through the provision of broader cultural education. KWY, along with the Principal Aboriginal Consultants (PAC) in DCP, advocated for Aboriginal families by expanding on the collective suffering felt due to cultural and intergenerational trauma. They spoke about the Stolen Generations and the impact it had on parental engagement and trust of government services. This advocacy directly impacted the level of cultural awareness held in cases.

This advocacy is best demonstrated with the MC Family, where KWY and the DCP PAC explained the behavioural responses of the parents as due to historic intergenerational trauma:

> *DCP: But then I'm also getting other services ringing me up accusing me of creating another Stolen Generation and abusing me, other Aboriginal services.*
>
> *PAC: Yeah, but you have to understand that's the trauma – with all due respect that is the trauma of a lot of Aboriginal people and don't take that personally.*
>
> *DCP: It's hard not to.*

PAC: I understand but you are working for an organisation that has done Aboriginal people wrong on so many different levels, and some of it does continue today. All I am saying is you can't take that stuff personal and unfortunately you are going to have to have those conversations, and we all hear that kind of stuff working for this organisation. It's the same with this mum, we have got to keep in mind that she has a history interstate. I am not saying she is a perfect parent absolutely, but she has a history of working with welfare services, and I get she is not communicating-

DCP: I dispute the working with, but never mind – of being involved with services yeah.

PAC: Correct and she's experienced removal of her older children historically. She has experienced of her younger children, but you can't ever – workers need to learn to put themselves in someone's shoes. Like imagine how that would make you feel if your child had been removed. I can bet your bottom dollar you're not going to sit there and say here take my child …

DCP: Honestly, I have been around a long time – she is not your run of the mill client. She is not, she has definitely got an aggression problem. She is definitely violent in her presentation and behaviour. (MC Family, Case review discussion 2)

This meeting provided an opportunity to deeply discuss the impacts of trauma and the importance of using a cultural lens to assess risk, interpret the behaviour shown by the family, and plan interventions. The bringing of KWY and DCP expertise together signalled an important shift in communication for this case. KWY also made more explicit requests to improve DCP's culturally responsive practice, such as requesting a PAC attend any DCP meetings where decisions were being made:

It is felt that having that level of Cultural authority in the room could well have a really beneficial effect on the outcome. This is especially so, if there is any chance that the removal of an Aboriginal child could be the outcome. (MC Family, Case file, email to DCP)

This persistent cultural advocacy ensured that the case was viewed through the lens of culture and historical trauma to accurately assess and respond to the family needs.

KWY also demonstrated DFV expertise through the ongoing use of their risk assessment tools and explanations of their service delivery. One of the important elements communicated to DCP was that of the 'lighthouse effect' whereby risk often appears to increase at the start of an intervention because more information is gained about the family. Here, the actual risk has not changed, only the perceived risk because service providers have greater knowledge of the concerns within the family. For example, as trust builds with a family, the victim parent may begin to share more extreme incidents of DFV that were previously not known. These incidents may increase the risk score on the assessment. However, this change does not mean the victim parent is in greater risk but rather that practitioners are now more aware of the risk. In addition to risk assessment, KWY also provided key information about the stage of change the parents were in and evidence for their assessment of the parent's stage of change.

The expertise held by DCP was situated in knowledge of their systems, pathways to either reunification or long-term care, and the breadth of information held about the families. DCP highlighted important factors to be considered for the long-term safety of children, for example, thoroughly assessing the perpetrator in the JT family for any cognitive impairment:

> *… our application is for the court at the moment for a 3-month order, and we will be looking at a mental health assessment for him, and potentially we can also look at, if we're not able to get any records for his head injury, we might even be able to look at neuro-psyche referrals. I guess just in terms of everybody being able to work and support the family, I think it's really important that we have that information …* (JT Family KWY 3, Case referral discussion)

DCP also provided information about the pathways through the child protection system. The experience of supporting families gave them insight into potential barriers and facilitators. This often connected with DCP's knowledge of the system, as expressed in a discussion about the RC family's reunification timeline:

> *… we've found with reunification court that's been good is if parents need a little bit more time, you know, it can – and rather than creating a whole new application, they can just extend it out by another six to eight weeks, because ideally, you know, when we're looking at reunification, the child or children go home, and then we still have a few months left of the guardianship order to monitor the situation. But there'll also be a very detailed case plan with that 12-month application with all the child protection concerns and what the goals and outcomes and expectations will be.* (RC Family, Case referral discussion)

Finally, DCP often held more holistic information than KWY. This meant they were aware of factors such as the parents testing positive for drug use or information from other organisations which influenced their case direction. At times, KWY was unaware of this additional information and so did not understand the reason for DCP's case direction. This was compounded by the way DCP staff engaged in the case discussion. DCP often led with legislation, policies, or procedures that guided their decision-making or limited their options. For example, in the PM Family, DCP could not keep the case open:

> *SLO: Why you want to close, why you think you're ready to close the case now?*
>
> *DCP: Because we can't keep it open without [court] orders.*

However, through discussion, greater awareness of the family's strengths emerged:

> *SLO: … the issue is [the perpetrator], isn't it? That [the mother is] unable to manage-*
>
> *DCP: It's about increased safety and wellbeing for [the mother]. So there have been some key factors. It's not about just not being able to close the case … And despite all the barriers that have been up there for [the mother], it was a significant period of time that it took Housing because of different issues,*

she grit her teeth and she stuck by it, around [the child], prioritizing his education, ensuring that the home is a safe environment for [the child] to be …

SLO: So, Mum's showing protective and parenting capacity?

DCP: Yeah

(PM Family, Case referral discussion)

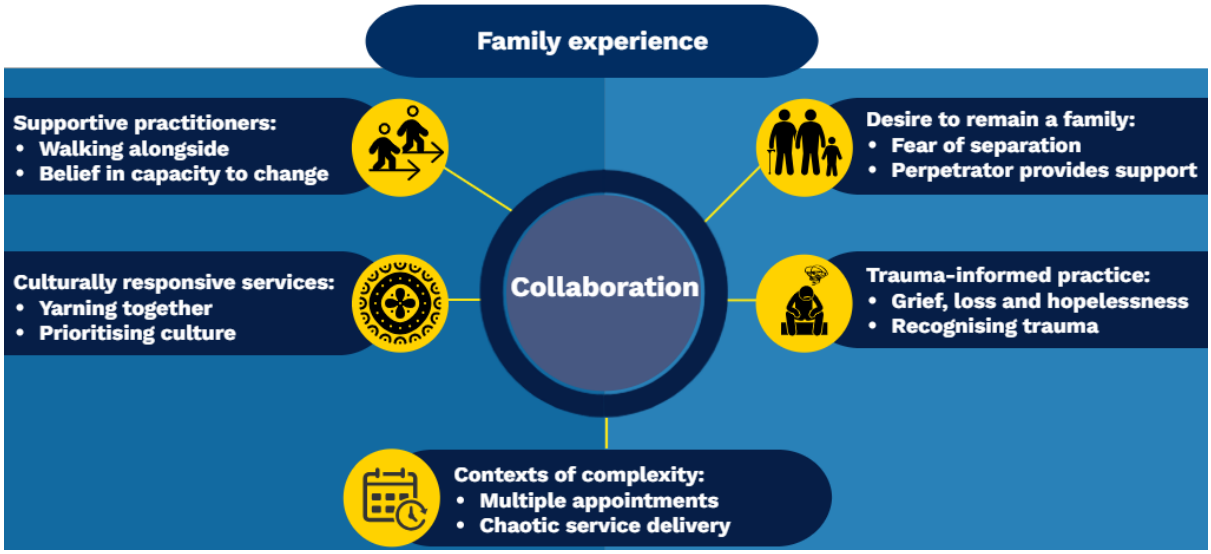
Consultations of DCP's expertise often followed this same pattern, with KWY querying the system processes or what DCP had decided was the overall case direction. It was only after additional conversation that the full range of factors were shared and the rationale for case decisions became more transparent. The prototype facilitated these in-depth conversations by creating space for DCP to share expertise beyond merely describing system processes.

Family Experience

This section identifies the experience of families working with both DCP and KWY. While families were not aware of the prototype itself, they were asked about their perceptions of each organisation and how they collaborated. They identified feeling supported by practitioners as critical to their success. The families who were able to achieve safety for their children not only felt supported by KWY but were highly engaged, using KWY for emotional regulation and to advocate with DCP. Communication improved when KWY bridged discussions between DCP and the family. They received culturally responsive services that aligned with their needs and built connection to others in the community. Because of the high levels of complexity, families had many appointments and struggled to maintain their schedules. DCP and KWY also had difficulty coordinating the demands they placed on families, and this led to competing priorities. Part of the complexity families faced was managing the impacts of historical trauma. Although these impacts were identified by both organisations, often the current behaviour of the families was not examined through this same trauma-informed lens. Instead, families felt that their trauma history was used against them and only seen as a risk factor. A final factor families identified was that they wanted to remain in a relationship and retain their family unit. When pressure was placed on the parents to separate, the victim parent's mental health often declined and ultimately, the parents resumed their relationship. Overall, the families highlighted relationships as central to their healing journey. The key factors are summarised in Figure 15 and discussed next, in further detail.

Figure 15

Summary of the Key Factors Associated with Family Experiences



Supportive Practitioners

The families who were interviewed found KWY to be supportive and helpful to their healing journey. Many of the parents who were most successful during the intervention period used KWY not only as a DFV service but as a source of ongoing support. For these families, KWY assisted with two key components: emotional regulation and advocacy.

The families spoke about feeling that KWY 'had their back' and so drew a sense of comfort and security from their attendance at other meetings with DCP. This supported their capacity to regulate in these meetings, enhancing their ability to engage in dialogue and absorb important information. The following series of quotes demonstrate how the families who were able to safely care for their children engaged with KWY:

> *KWY staff were really lovely. She checked in on me every – every couple of days when my grandpa was at home. … When he was going [to pass away]. So, she checked in on me every couple of days. And just made sure I was still okay and – because it was just – it was horrible time for us.* (BA Family, Female interview)

> *I couldn't be even more happier that we have them [KWY] there because if we didn't have them apart from our counsellors we wouldn't really have anyone where KWY is always there. For the meetings they're there, if I call, they're there. If I am stressed like today, I can ring [KWY women's practitioner] and if I can't get through to her, she calls me back.* (MC Family, Female interview)

> *As you know, that was KWY worker on the phone. I spoke to him yesterday, we talked for about half an hour, I was just filling him in on how Tuesday went, and I'll speak to him two or three times a week*

> *outside of our one-on-one time and he'll ring me every Friday just to remind me about ARC [therapeutic group] but you know, yeah.* (RC Family, Male interview)

> *Oh, it's just been great [working with KWY] … Any sort of little help, food assistance, or any sort of help.* (PM Family, Female interview)

For these families, KWY walked alongside them throughout the intervention period rather than just delivering a single service. One of the strongest effects of this was that KWY helped families remain engaged with, and responsive to, DCP. This is best illustrated with the MC Family, who had a contentious relationship with DCP. There were instances where DCP called KWY to help with emotional regulation or communication with the family. For example, when the MC Family infant was removed at birth, DCP called KWY and requested help to "*de-escalate*" the mother and explain "*the process to her*" (MC Family, Case file).

Similarly, in cases where a rupture occurred between DCP and the family, KWY facilitated ongoing engagement. For example, the MC Family's shared case plan stated, "*DCP reported that there needs to be repair work between DCP and the family to find common ground where both parties can work together to resolve the child protection concerns*" and "*KWY to help with the rapport building process to build a respectful common ground, this is particularly important if the family was to go into the reunification phase*".

KWY also facilitated communication in a practical way that consistently created a bridge between the families and DCP. The mother in the MC Family explained that she restricted her communication to only KWY stating, *"So, yeah, the only communication I have, like is with KWY, and they'll let us know up on things, or I'll ask them to ask DCP*" (MC Family, Female interview). This allowed the family to continue their communication indirectly with DCP while the mother worked on regulating herself better during meetings, where DCP often interpreted her behaviours as threatening.

Similar themes were seen in the other cases. As a result of trusting KWY, families were more transparent with DCP. For example, the victim parent in the RC Family became pregnant during the reunification process. She was scared to tell DCP as it might influence the reunification negatively. KWY supported her to call DCP and explain that she was pregnant. These instances of KWY reaching out to DCP occurred frequently throughout the cases. They bridged the communication between DCP and the parents, helping both sides to take perspective.

In some cases, the family also found DCP practitioners to be supportive. They emphasised the importance of being believed and having someone who put "*family first*" rather than seeing removal as the only option:

> *… big props to our access worker Jo who is just amazing, she's like part of the family. So that relationship we've sort of built a little bit with DCP or our social worker and access workers and that, it's amazing … I'm glad that at least DCP does, I believe, try and keep children in the family first.* (RC Family, Male interview)

Often these families highlighted that their specific DCP practitioner was different from the 'others' at DCP and felt they built an individual relationship. Some families had prior experience with DCP and reflected on how the different approaches of practitioners can either build or erode trust:

> *I had a really good experience with [DCP] this time. They were good with everything. And they – not once did they threaten to take the kids away.* (BA Family, Female interview)

This trust resulted in families feeling more confident to advocate for themselves. The victim parents in particular, were better able to explain what they needed to keep themselves and their children safe, rather than fearing that more information would result in the children being removed.

Culturally Responsive Services

One of the ways that KWY was able to successfully engage families was through culturally responsive services. While this was important in all cases, it was most demonstrated in the case of the PM Family. KWY provided cultural expertise about the male's position in the community and how he may not respond to female direction. They identified another contact who could provide more information about the male's position and highlighted the importance of community endorsement:

> *But sometimes you have fellas calling themselves things when they're not. So, it'd be good to see what [names a male] take on that is, and how much history he knows behind that … That would be a good start. So, all that cultural stuff, we'll talk about that in house… the men's business.* (PM Family, Case referral discussion)

One of the key child protection concerns was that the son in PM Family was not taking his medication. A further complication was that the victim parent believed the perpetrator had cured the son of his condition. KWY assisted her to integrate Western and Aboriginal healing, this meant that the son would receive his medication as well as recognising his traditional healing. Finally, KWY facilitated a yarning circle to bring the family together and improve their interactions. Here, the son was able to express some of his worries about the family, such as being unable to sleep at night because of the loud noise from fighting. The parents spoke about their worry that he was not following the household rules or taking his medication.

Overall, KWY highlighted the importance of cultural responsiveness and how effective their programs were:

> *KWY: Yeah, and those visits that we have, and our healing, our cultural healing programs, we find are really good for change, initiating change. We're not finding all the clinical therapies working that well for our clients, as what [colleague] was saying, you know, we've got this thing about colonisation and not trusting organisation, departments in particular. So, our healing programs are really important for our families to get involved with, particularly the males, because they are mainly the perpetrators of DV, and we want them to see that straightaway, that that's their role to take ownership of DV in the family and how it's impacted on the children and their partner* (RC Family, Case referral discussion)

KWY were also active in supporting cultural connection for children in their placements. During the case discussions, the liaison officer asked about cultural activities, kinship scoping, and advocated for regular access visits with the parents. This provided a strong cultural voice throughout the intervention. KWY groups, such as Heart 2 Heart, were facilitated by elders and explored culture.

Some families did not wish to explore their culture or were unsure of their Aboriginality. For example, the mother in the JT Family thought her Aboriginal heritage was just a rumour:

> *Well DCP helped me find – figure out that I have got Aboriginal blood. I didn't actually know I did. My mum told me – used to tell me. But I didn't think that we did.* (JT Family, Female interview)

KWY supported these families by exploring family connections or introducing them to ideas about Aboriginal cultures. Each family member was assessed on their cultural connectedness in the case plan, with a specific goal identified. KWY also consistently updated DCP about the family members' cultural identity. As they gathered more information, specific language groups and cultural connections were identified. DCP then worked to ensure their record keeping system was updated with the child/ren's cultural identity and that the Aboriginal Child Placement Principle was followed. KWY consistently highlighted the importance of locating kin, and this was a dominant feature at the start of many case discussions.

Contexts of Complexity

All the families who were interviewed lived in contexts of complexity. As a result, their reunification/family preservation journey meant navigating multiple, and sometimes competing, appointments. Without collaboration, this could result in chaotic service delivery. Some families were confused about the number of services involved, the days they were meant to attend, and key events that were occurring. Both DCP and KWY identified that they needed to communicate clearly and support families to attend appointments:

> *KWY: … obviously just for all of us, just making sure that we are checking in with one another I think would be really important, just so we are giving really consistent messages, particularly to [father] because he does, he mixes things up quite a bit from what we've seen. You know even like meeting dates, like coming into the office like on a day that no one was due to see him, thinking he might be on that day ...* (JT Family, Case referral discussion)

This was a particular concern for the JT Family as the perpetrator displayed behaviours possibly indicating a neurological condition. KWY supported him by liaising with DCP to ensure that the perpetrator did not miss any appointments scheduled by DCP:

> *[The father] stated that he had been advised of an appointment with DCP on Thursday afternoon (20/5/21) but could not remember the details. [Men's worker] stated that he would ask [DCP case worker] to clarify the details with [the father]. [Men's worker] emailed this request for clarification to [DCP case worker] on 19/5/21.* (JT Family, Case file)

It was also important for DCP and KWY to coordinate their own service delivery so that it did not create further chaos for families. For example, KWY case notes for the JT Family stated, *"DCP scheduled the family for Parenting Capacity Assessments on this date, without advising KWY. Parents advised and outreach was cancelled on the day*." This was not an isolated incident, and KWY often seemed unaware of the appointments the JT Family parents had booked with DCP. In another example, an outreach visit was planned with the perpetrator while he was spending the week in detox.

The most common issue was DCP scheduling drug testing during KWY's planned outreach visits. In some instances, KWY brought up these issues in the case review discussions and asked for appointments to be coordinated:

> *KWY: So, just that, I realised that the drug test has to be random, but if they're possible to be random not on the Tuesday at 10 when we're seeing them, or at 2 o'clock on Friday when [worker] is on, that would be fantastic, because then that means they get the support they need.* (RC Family, Case referral discussion)

The clashing appointments highlighted some of the different goals held by the respective organisations. DCP arranged appointments for assessment and to gather evidence for their case direction, whereas KWY arranged appointments to offer support to the family.

There was also a power imbalance between the two organisations which impacted collaboration. A KWY practitioner explained this further in one of the working groups:

> *So, when you look equality of booking interviews for example, DCP will potentially just book an interview, a psych assessment or something which is important for them, it's important for the client, but which clashes with say ARC which is also important for the client but … because they, they trump our ace, that, the psych … goes forward regardless of anything else* (KWY working group)

Even when appointments were coordinated, they were often overwhelming and a source of stress. Further, the appointments did not always consider the practicality of the families involved, such as distances travelled or the unreliability of public transport. The perpetrator in the JT Family commented on this challenge:

> *They were pumping us with so many appointments there wasn't a day a week we didn't have anything and then it would be like baby contact today but you have got an appointment at 11:45 and you've got an appointment at 12 o'clock, but you don't finish contact till 11:30. It's like, and so that appointment in the south because that's where we live, but bub is in Hindmarsh and you expect me to be back in the south for 15 minutes when the train takes 27 do you know what I mean?* (JT Family, Male interview)

The families were concerned that any complaints about the appointments would be seen as not engaging. Each time they were seen by a service provider they were under scrutiny which created ongoing stress. The victim parent in the BA family spoke about the effect on her children:

> *… the kids are sort of pretty traumatised by it all as well. So yeah, [I would like to] have time with the kids where we're not stressed about these people coming over. And – because they do get on your case about cleaning the house.* (BA Family, Female interview)

Overall, families still identified ongoing chaos in service delivery. They felt overwhelmed by the number of appointments and that they often did not fit into realistic timeframes. Even DCP and KWY had clashes of service delivery which confused the parents and reduced the support KWY could offer. As communication improved between the organisations, more predictability was created for the parents. Often this occurred when the assessment focused appointments of DCP respected the support-based appointments of KWY, so that cancellations and reschedules were not needed.

Trauma-Informed Practice

The families spoke about the importance, and challenge, of remaining hopeful during reunification while addressing their own trauma. Several parents had prior involvement with DCP, which created further vulnerability due to their historical trauma being triggered. For Aboriginal families, the removal of their children fit within a broader historical context where it was almost normal to lose a child to statutory services. A sense of helplessness pervaded the stories as they spoke about how their children were removed:

> *Interviewer: And so, then DCP came and saw you in the hospital and took your son?*
>
> *Victim parent: No. I just passed baby over to the nurse and just left. I was- I didn't want to go through that. My son getting taken away from welfare in front of my face, you know. I didn't want to go through that. I just passed him to the nurse straightaway. So, if this is what I have to do, I have to do it, you know. Here you go, take my baby away from me.* (PM Family, Female interview)

This hopeless view was reinforced by other professionals. For example, the lawyer for the RC Family told the parents, "*DCP is prone to ticking the 18-year order box as opposed to what they're telling you they're going to tick".* The male partner indicated that he was encouraged by others to not believe DCP when they said they were working towards reunification. This distrust was further reinforced by systemic racism and the direct experiences of the parents:

> *[DCP staff member said,] 'You know that your baby didn't take, get taken because you're Aboriginal' … it still plays on my mind now … why would you say that if that wasn't the case, like you wouldn't say those words.* (RC Family, Female interview)
>
> *[An unnamed support person for the family] put it to us like this: so, for instance if an Aboriginal family misses an appointment at the hospital or reschedules as it were, an appointment at the hospital apparently that gets red flagged with DCP straight away* (RC Family, Male interview)

The accumulated sense of discrimination and powerlessness left the parents feeling hopeless about how to respond. They experienced significant grief and loss but were quickly put on timelines by DCP to engage with

interventions. As discussed earlier, the parents were not given time to grieve and instead faced short intervention periods to demonstrate their capacity for change.

The trauma response of these parents was sometimes perceived negatively. For example, the victim parent from the SK Family revealed an extensive trauma history, likely impacting her ability to describe her autobiographical narrative. She gave birth to her first child at 14 and was mostly raised by her grandparents. She described ongoing violence with all members of her family, stating that to her DFV was normal. She said that her partner used violence but attributed this mainly to his drug use, and now that he was sober, the violence had abated. The long history of violence was traumatic to her and influenced her engagement with DCP. She was unable to go into depth about her history, with her the trauma being fragmented in her mind. This was reflected as a negative trait by DCP, as though she was not engaging in the parenting capacity assessments. A similarly punitive response occurred when she cried when her children were removed. The victim parent said was expected to remain calm for the sake of her children and her emotional distress was portrayed as unstable. She explained that she did "*not know what was happening*" and that the removal occurred on a long weekend. She was very emotional during the removal and stated that DCP "*held against me that when my girls were taken, I broke down and cried*" (SK Family, Female interview).

The perpetrator of the SK Family had a different response. He described his understanding of DCP's involvement and their expectations of him in a short and simple manner. He felt he needed to do whatever they told him to do, stating, "*Just got to do what DCP tell me to do, basically*." He highlighted that he had no power and that DCP had all the control, which he resented as he was a foster child himself. The perpetrator had an 11-year-old child in DCP's care, describing this as the second time DCP took his children away. When asked how he felt, he said he felt numb stating, "*I'm used to standing up and taking my punishment*".

The data gathered from the family interviews showed that parents felt DCP did not understand their trauma history. In contrast, the data in the case discussions was more balanced, with DCP acknowledging trauma as a factor in behaviour. For example, in later case discussions about the SK Family, DCP showed greater insight into how trauma affected the victim parent stating, "*[The mother's] trauma would be the grief and loss unresolved from losing Mum and being sexually abused by family. I feel like she's stunted in the age where she was sexually abused, she's stuck*" (SK Family, Case discussion 3). However, by this point in the case discussion, the decision for long-term orders had already been made. An earlier assessment was conducted by a neuropsychologist, which resulted in a list of potential referrals, but service delivery was not adapted to meet the needs of the victim parent.

An analysis of the word 'trauma' showed that it was often referred to historically (for example, the parent experienced trauma), or in terms of treatment (for example, the parent needs trauma therapy). There was less use of a trauma lens to identify the parents' current behaviours, especially their engagement with services. KWY spoke more openly about trauma and played a significant role in holding this trauma lens in mind during discussions:

> *Okay I think my eye over this has always been looking at the historicals that are around it as well … also their history of her family, and the history of his family and some of the historical stuff that's been happening there and we're seeing the similarity that's gone down in this. So normalised behaviour that shouldn't be normalised. So, I think for me looking through those traumas, that those traumas unpack that so you can see that some things were a bit abnormal and not normal, because it's a different world.* (MC Family, Case review discussion 3)

Even when families identified a history of trauma, it could be used against them as it was classified as a risk factor. For example, the father in the MC Family spoke about his history being used against him in a court report:

> *… they asked about what my childhood experiences were and stuff like that and then that will come up, 'Oh he was abused as a child. There's a possibility he could abuse his own children in that sort of way'* (MC Family, Male interview)

Overall, the families highlighted significant trauma histories, often extending prior to DCP's involvement. Their every action was scrutinised and, without using a trauma-informed lens, could be misinterpreted. The families who remained engaged and achieved their case plan goals focused on support from KWY to maintain their momentum. KWY also provided a trauma lens during case discussions to better interpret behaviours.

Desire to Remain a Family

All the families interviewed identified wanting to remain as a family unit. Even in cases where the parents said that they did not wish to continue their relationship, most had resumed living together by the close of the intervention. The victim parents did not want to end their relationship but rather be safe within the relationship.

This desire to remain together was challenging within the risk management practices used for DFV. The families reported that DCP often required those identified as the perpetrators to be removed from the home, or for the victim parents to cut off all communication with them. Typically, this 'requirement' applied to the perpetrator, but in the MC Family this included a mother's two oldest children. The KWY case file noted the following, "*[The mother] expressed that she is upset that she has had to kick [older child] out as she barely sees him".* The note also highlighted the impact on the other son who felt responsible for his siblings being removed:

> *During the period of engagement with KWY DCP focused in the behaviours of both [two siblings]. The boys were labelled as a risk to the reunification of their younger siblings. CYP concerned that this was a lot of pressu[re] and spoke with [young person] reassuring him that he was also a young person and making mistakes was a normal part of being a teenager. [The young person] expressed he loved [his] younger siblings and would not hurt them. CYP encouraged [young person] to talk w[ith] people he trusted, if he felt pressured or overwhelmed during this time.* (MC Family, Case file)

Because families wanted to remain together, they felt anxious at DCP or KWY learning about any risk in the home. The families anticipated a punitive response and so withheld information or minimised the violence. A

clear example is shown in the PM Family, where the victim parent links minimising language with a desire to protect the perpetrator:

> *I told them that I did not want to charge him with any charges against my – my old husband, my old man. Father of my son. I did not want to charge him with anything. Even though he gave me a black eye. I did not want to charge him with it. It was just a little push in my forehead, a – a little crack on my forehead and it gave me a black eye. And so I didn't want to charge him with anything … I – I was going to. But then I just, no I don't want to, I just want to work – get help with working, with family, with all of us.* (PM Family, Female interview)

In some cases, the parents were told to separate (as perceived by them) by various professionals. The forced separation put strain on the parents, as they could not turn to each other to cope with the emotional loss of their children. The RC Family described wanting to go home together after their daughter was removed but the hospital staff reportedly would not let the victim parent leave:

> *And [hospital staff] were trying to get me into a DV hotel, and I was like I just want to go home, like you know because of what had happened in the hospital, they wouldn't let me go home, they kept me in an extra two days because they didn't want me to go home, I said he's not violent … And so they said to me if I went home back to him, that I wouldn't get a social worker to support me, but if I want to the DV hotel that I would get a social worker to support me, and I was like I'm not losing my partner and my baby all in the same week, like this is ridiculous.* (RC Family, Female interview)

Often, the victim parents spoke about the perpetrator as a source of support. They highlighted both emotional and practical support and did not want to be separated. At times when they could not be together, the victim parent's mental health declined and negatively impacted her parenting. For example, in the BA Family, the victim parent was excited for her partner to be released from incarceration:

> *No, I can't wait for him to get out [of prison] … as there's been a lot of crap in our lives, he has still been there for me. And I suffer from a really bad anxiety disorder. And having panic attacks when he first got locked up. And yeah, it's – it's been very difficult. And he's sort of been my main support for a lot of years, yeah.* (BA Family, Female interview)

Even though the women interviewed wanted to remain partnered with the perpetrators, they still wanted support to address the power dynamics underlying the DFV. For the BA family, the parents resumed living together, but the dynamics had shifted for the victim parent and children, providing them with more safety:

> *And [DCP] just basically shut [the father] and his family down straight away. And just said, 'Look yeah, you're not allowed to pick them up from school. You're not allowed to see them unless it's [mother's] terms, yeah.' So that – that was helpful as well. It meant that [the perpetrator's family] couldn't sort of pull their manipulative stuff and get what they wanted.* (BA Family, Female interview)

Overall, any attempts to separate family members did not reduce risk. Instead, the fear of separation led to the families hiding risk or additional stress placed on the victim parent. In this case analysis, all the families remained together, regardless of the decisions made by either DCP or KWY. This was particularly challenging as it was often the perpetrator who disengaged from services, with KWY and DCP continuing to work with the victim parent.

Discussion

This report provides an overview of work conducted between Kornar Winmil Yunti (KWY) and Department for Child Protection (DCP) at the intersection of domestic and family violence and child protection. The Social Work Innovation Research Living Space (SWIRLS) at Flinders University co-designed, collected data, and analysed practice at this intersection over two years. This report outlined the establishment and implementation of the collaborative service response articulated through the prototype including being culturally informed, trauma responsive and informed by a family violence lens. In the development of the collaborative prototype, the practitioners in KWY and DCP articulated what they wanted to establish a formalised collaborative service response between KWY and DCP that was culturally responsive, facilitated shared understandings of family violence and risk, and enabled early intervention (in the context of child protection) to reduce referral "churn" and entry into out of home care. These themes of culturally responsive, sharing, and early intervention are discussed in the context of the research questions - Did the prototype make a difference to workers and families' experiences of collaboration and Who is benefiting from the prototype?

Culturally Responsive Service Provision

One of the essential outcomes for the project was implementing a collaborative service response for KWY and DCP that was culturally responsive. The findings outlined in this report show that culture was situated within prototype with identified benefits for practitioners and the families who were central to the collaboration. As identified by (Moore et al., 2023) collaboration between an Aboriginal Community Controlled Organisation and child protection can be complex and challenging especially due to the historical and discriminatory experiences for Aboriginal people. A culturally responsive and safe service delivery response was enabled through building relationships between workers across the different organisations as well as between workers and family members, often enabled by KWY. Shared understandings and accountability between agencies grew across time, however, were often instigated by KWY and hence some redress of unequal relationships, structures, and outcomes were possible. A respect for Aboriginal ways of working (Moore et al., 2023, p.203) was also evident across the life of collaboration.

The establishment of the authorising environment, with strong leadership and governance inclusive of Aboriginal practitioners, enabled the mobilisation of a shared vision and practice approach. The Advisory and working groups were inclusive of senior Aboriginal practitioners from both DCP and KWY. The co-design process was also inclusive of Aboriginal practitioners from both DCP and KWY which formalised a prototype that was

informed by a cultural lens. The prototype clearly specified that culturally safe and responsive practice would only be achieved by Aboriginal Cultural Consultants from DCP and KWY staff being present and leading conversations in all stages of the collaborative service response which ultimately would benefit families.

The inclusion of specialist Aboriginal voices and Aboriginal senior practitioners was identified as a strength of the prototype that 'cannot be underestimated' (Connolly et al., 2017, p.5). Integrating Aboriginal knowledge and expertise at both the operational and strategic level of governance presented a valuable opportunity for cultural voices to influence the larger service system. Integrating Aboriginal ways of working and knowing afforded a space for legitimacy and intersectionality. These shared values and ethics, however, should not be taken for granted, or approached as static or a given (Moore, 2013, p.112), as the findings showed these needed to be consistently named through 'contested democratic space' (Hartley et al., 2017) to enable different pathways to collaboration and produce better practice.

The privileging of Aboriginal knowledge and expertise, as well as appreciation for Aboriginal community as a source of strength and protective force for children (Geia et al., 2011; Lohoar et al., 2014) was well-recognised by participants groups in the research as a key strategic impetus for effective intervention. The project design was characterised by inclusive participation and strategic direction from senior Aboriginal family practitioners and Principle Aboriginal Consultants (PACs), as well as senior community leaders, who were active participants in both the Advisory and Working groups. The accountability to Aboriginal governance in the authorising environment had clear aims to generate culturally informed practices at the intersection of child protection and DFV (Connolly et al., 2017; Wendt et al., 2021). Moreover, the inclusion of Aboriginal voices afforded the opportunity for Aboriginal perspectives and expertise to shift approaches to domestic and family violence in different ways. The centrality of culture and culturally responsive practice was recognised through demonstrated intervention with the families and highlighted in feedback by the families. Intervention was reflective of Aboriginal ways of knowing, being and doing, and ensured that cultural connection and voice were recognised as critically important elements for children who were in out of home. An important finding from the research highlighted that KWY supported families who were disconnected from culture to establish cultural connections through the locating of kinship relations and exploration of their cultural identity. KWY was able to successfully engage families through culturally responsive services. These practice interventions are reflective of the principles that increase the effectiveness of interventions to family violence in Aboriginal communities (Lovett & Olsen, 2016). Olsen and Lovett (2016) advise that interventions should be focused on building family cohesion, healing individual and community trauma, and helping both victim and perpetrator deal with their pain and intergenerational trauma. It was also evident that KWY enabled families to engage with DCP. For these families, KWY assisted with two key components: emotional regulation and advocacy. One of the strongest effects of this was that KWY helped families remain engaged with, and responsive to, DCP.

Strengthening the relationships between the sectors and responses to Aboriginal children and families, requires a relational interaction that facilitates respectful discussion with aims to 'breakdown communication and social

barriers' between Aboriginal and non-Aboriginal persons (Geia et al., 2013, p.16). Building respect and trust in partnership with Aboriginal organisations is fundamental to a collaborative service response. Aboriginal community perspective and emphasis on relationship-building and cultural connection with families can help to reduce the types of violence that can be aggravated during the intervention process by instead offering a 'reflexive sound board' across conflicting perspectives and approaches (Stanley & Humphreys, 2017, p.112). Relationship building between KWY and DCP was always present across the two-year project, navigating respect and trust. Similarly, building respect and trust with families was particularly seen in the work of KWY, which offered new engagements for families with DCP.

Building collaborative relationships was not without struggle (Hester, 2011) and the findings showed that at times KWY and DCP misunderstood each other or had different viewpoints regarding safety, risk, and assessment. The project found that to work through this struggle, the authorising environment of the Advisory Group and working groups were an important place of contestation where different views and values could be articulated away from the family (Benington & Moore, 2011, p.6). Senior Aboriginal practitioners participated at the strategic and operational level of the prototype and provided legitimacy and support to the authorising environment through their cultural authority and expertise. Yet without a clear practice infrastructure that is *accountable* to this authority, it can be seen that Aboriginal expertise will sometimes be diminished when working with the statutory authority. The lack of delegated authority and power of the cultural expertise can sometimes result in DCP's making the ultimate decision with legal power and ignore the expert advice and opinion of Aboriginal ways of knowing and being and override a joint risk assessment.

Aboriginal family's involvement with statutory authorities and removal of children occurs within a backdrop of the damaging intergenerational impacts of colonisation, such as past policies of forced removal and the continued disadvantage Aboriginal people experience (Baidawi et al., 2017; Cripps & McGlade, 2008). Similar to research that shows this context exacerbates a sense of powerlessness and hopelessness and ongoing discrimination in statutory context, this project found some of the families were extremely vulnerable due to previous involvement with DCP therefore triggering experiences of historical trauma. The findings suggest that for some of the families whose children were placed in alternative care, they were presented with restrictive timelines without acknowledgement of their grief, loss and ongoing trauma at times their reaction to such removal was perceived negatively. Information emerging from families demonstrated that they often did not feel that DCP understood their experiences of trauma, and it was KWY that enabled a more balanced approach to understanding behaviours of families.

Despite challenges across the day-to-day practice of KWY and DCP, the project found that the authorising environment and the clearly delineated prototype allowed for a reflective and conversational space to build collaboration. The active participation of both organisations facilitated relationship-building and enabled competing perspectives to be named and for all to engage in a joint effort to reduce the power dynamics across the statutory and non-statutory service sector. The collaborative prototype provided a structured process

whereby stakeholders were able to develop new ways of working by talking about shared understandings, goals, and brining historical and cultural knowledge to the fore to understand family contexts.

Sharing Information and Managing Risk

The prototype co-designed by DCP and KWY was a structured service response articulating clear processes for referrals, interaction with families, sharing of information, shared language and theoretical understandings, establishing shared case planning, decision making, and sharing of risk. There are many articulated advantages in the literature that highlight implementation of collaborative responses can reduce the duplication of work, improve communication between service providers, increase accurate risk assessments, and provide less-fragmented service provision (Humphreys & Healey, 2017; Laing et al., 2018). Effective and sustainable collaboration is a complex process and is often dependent on the availability of financial resources, articulated policies and processes, and dedication of actual time and energy. Investment in time and energy propels motivation, generates trust and builds relationships, leading to sustainable and creative collaboration outcomes (Thomson & Perry, 2006; Thomson et al., 2009). The prototype or collaborative service response provided an example of a structured collaborative process that articulated the following: eligibility criteria; elements to ensure a culturally responsive approach; establishment of referral processes followed by a warm referral; processes to facilitate open communication, sharing of information, and sharing of risk; specified interventions to be implemented by KWY; communication strategies; processes for case review discussions, and responses for lowered risk and when risk continues to be high. However, the analysis of data also found that building collaboration from the prototype required extensive time and energy, which some reported was a pressure for them in their day-to-day work.

Despite the pressure of time and energy (without diminishing this observation), the findings indicate that the formally established processes of co-design of the prototype did generate positive outcomes for practitioners. Professionals coming together through co-design and case discussions facilitated sitting, learning and discussing complex issues experienced at the intersection of domestic and family violence and child protection resulting not only in the establishment of a respectful working alliance, but also institutional empathy and improved communication. The established processes embedded in the prototype also resulted in cultural and systemic changes and opportunities to share information within and across agencies which ultimately benefitted the families. Conversations and discussions enabled practitioners to understand each other's roles and responsibilities, policies and practices and develop a shared understanding and language in relation to domestic and family violence, risk, and cultural safety. These discussions were not one off but continued to occur throughout the case discussions. Regular case review discussions provided the momentum for the progression of policy and practices, identification of other relational opportunities and establishment of other collaborative processes such as co-location and sharing of resources across agencies, and information sharing. As per findings by Malik et al. (2008) practitioners were also involved in the sharing and understanding of cross-agency

screening instruments and improved screening practices that informed shared decision making and case planning.

These processes facilitated engagement and an observable shift in language, with victims offered support and understanding rather than blame (Banks, Dutch, et al., 2008; Banks, Landsverk, et al., 2008; Lalayants, 2008; O'Leary et al., 2018) and perpetrators were increasingly spoken about in case discussions, which assessed patterns of behaviour and the impact of their violent behaviour. However, it was also found that children were not as visible as the perpetrator or the victim parent. Discussions focusing on the children were predominantly about their placement and observations made during family contact rather than their needs or wishes.

The project also showed there were impediments to achieving effective collaboration such as diverse organisation philosophies and approaches, lack of information sharing, challenges surrounding resources, power dynamics between agencies, and communication issues (Langenderfer-Magruder et al., 2019).The findings indicate that there were barriers in relation to information sharing and decision making, particularly for some families whose children were subject to legal interventions. Organisations such as DCP hold statutory powers and were reluctant to share information with KWY at times and informed them and the families that access to information would occur through legal avenues. An important objective of the prototype was shared decision making; however, the findings indicate that was not always easy to achieve. In some circumstances DCP made decisions about families without consultation and communication with KWY, and when challenged it was unclear as to the rationale for these decisions which contravened the ethos of the collaborative service response. Power dynamics perhaps sat at the heart of decision making that was neither shared nor collaborative, which is not unique to this jurisdiction (Langenderfer-Magruder et al., 2019). Practitioners with decision making responsibilities did not always attend the case discussions and made decisions where legal knowledge and authority took precedence over other forms of expertise. DCP staff often referred to their legal directorate, family lawyers, or Crown Law as holding this authority, which limited their collaboration with both KWY and the families. Although lawyers were not present in the case discussions, legal expertise remained an ever-present concept. Decision making that was not shared was not conducive to positive outcomes for families evidenced through families identifying ongoing chaos in service delivery. Some felt overwhelmed by the number of appointments and that they often did not fit into realistic timeframes. At times, DCP and KWY had clashes of service delivery which confused the parents and reduced the support KWY could offer. As communication improved between the organisations, more predictability was created for the parents. Often this occurred when the assessment focused appointments of DCP respected the support-based appointments of KWY, so that cancellations and reschedules were not needed.

On the other hand, there were situations where DCP reviewed their decision following consultation, risk assessments, and sharing of information with KWY. Consultations of DCP's expertise often followed this same pattern, with KWY querying the system processes or what DCP had decided was the overall case direction. It was only after additional conversation that the full range of factors were shared and the rationale for case

decisions became more transparent. The prototype facilitated these in-depth conversations by creating space for DCP to share expertise beyond merely describing system processes.

One of the unique features of the prototype was the employment of the Specialist Liaison Officer (SLO). This was newly created position that provided a deliberate and strategic link between KWY and DCP. This position was responsible for the operationalisation of the prototype at the practice of family violence and child protection. The SLO was responsible for screening of referrals, facilitating of case discussions and case reviews, facilitating interviews with families, and identifying any issues that emerged in relation to the implementation of the prototype which was then communicated to the working groups for formative changes if required. Essentially the SLO was the contact point or link between the organisations in relation to sharing of information and specialist consultations about referrals and service provision.

The SLO was identified as a key position across agencies who nurtured relationships and facilitated open, transparent, and clear communication. In addition, the SLO was a conduit for faster, more informal, and explorative discussions. This was particularly important in situations where increase in risk identified, or further notifications were received by DCP. The establishment of specialised position or co-located practitioners were identified as the most effective in forming a bridge between the sectors (Banks, Dutch, et al., 2008; Banks, Landsverk, et al., 2008; Friedman et al., 2007; Langenderfer-Magruder et al., 2019; O'Leary et al., 2018; Tsantefski et al., 2018). Specially created specialised or co-located positions were seen to be advantageous in several ways. First, the positions created a formalised link between two sectors facilitating the ongoing development of collaborative services, building of professional relationships, enabled cross-system information sharing and communication, promoted institutional empathy and appropriate management of cases at the intersection of domestic and family violence and child protection. Furthermore, it was the SLO that was often able to use the prototype to help minimize blaming of the non-offending parent, provide support and advocacy for all family members, talk about the perpetrator and co-ordinate the efforts and services for multiple agencies" (Banks, Dutch et al, 2008). Second, these positions also focused on broad system issues and contributed to the development of processes and protocols such as needs assessments, screening and assessment protocols and required training forums. Langenderfer-Magruder et al. (2019) found that co-location of practitioners resulted in enhanced collaboration and marked reduction in the removal rates of children which was evident in this study.

Early Intervention for Aboriginal children

At the initial conceptualization of the prototype, it was anticipated that the prototype might ensure that Aboriginal children and families were referred by DCP to KWY to receive early intervention (in the context of child protection) to reduce referral "churn" and entry into out of home care. In this context of early intervention, it was identified that children, young people and families who were subjects of child protection and experienced family violence would receive a service as early as possible preventing an intervention that focused on removal of the child. This vision of early intervention was to reduce the prevalence of Aboriginal children and their families becoming entrenched in the child protection system. The high prevalence of Aboriginal children within the child

protection systems in Australia is well documented (AIHW, 2022) and is inextricably linked to intergenerational trauma and the continued and profound impacts of colonisation and polices of Stolen Generation (Baidawi et al., 2017; Cripps & McGlade, 2008). Other factors contributing to over-representation is also linked to the over-reliance on statutory child protection services without effective and sustainable collaboration across government and Aboriginal Community Controlled Organisations (Baidawi et al., 2017). The prototype between DCP and KWY was viewed as a mechanism to effectively and sustainably build effective collaboration, which was seen as possible through formalised structures and processes.

Blagg et al (2018) argues that mainstream child protection and family violence organisations have often been culturally neutral with a lack of understanding of the history, culture, and specific needs of Aboriginal people, and that parenting and family structures are often assessed by western standards, which continue to reinforce contemporary colonising practices (Moore et al. 2022). These circumstances mean that Aboriginal families are less likely to seek and receive support that is culturally safe in relation to their specific needs and leaves women and children at greater risk to violence (Tsantefski et al., 2018). This research project demonstrated that collaboration that is culturally safe and responsive is possible and was largely enabled by KWY occupying that space because they had a 'hands on approach' and meaningful role to work with Aboriginal families at the intersection of family violence and child protection. The prototype provided a structured approach where KWY engaged alongside DCP from the beginning of the intervention with families participating in the sharing of information, shared decision making, open and regular communication, being respected for their expertise and knowledge, and enabling self-determination and empowerment of families. Both organisations occupied the space for collaboration where DCP, in the main, did not step away from their statutory roles, responsibilities and practice but worked in partnership with KWY to lead intervention with families. It is important to acknowledge that even in circumstances where decision making was not shared and the ethos of the prototype was not implemented in its purity, KWY was able to challenge or engage in further discussions to ensure ethical, just and culturally responsive outcomes for children, young people and their families.

Unfortunately, the findings of this research indicate that the collaboration between DCP and KWY did not achieve the vision for early intervention as originally planned. Of the six families who participated in the interviews and who were the focus of the collaborative service response, four had extensive previous involvement with child protection. It was also evident that all six families experienced complexity beyond family violence and hence all the children lived in contexts of adversity characterised by violence and parental substances abuse, and most had been removed from the care of the families disrupting familial relationships. All the victim parents experienced family violence, poor mental health, and engaged in the use of drugs or alcohol. All the men who used violence also misused drugs or alcohol, were unemployed, had poor mental health and some identified childhood trauma as a contributing factor. The children and families referred to KWY by DCP for intervention were not early in their journeys of adversity and had often already met the threshold of removal and hence KWY stepped into a supportive role for reunification (if possible). The findings also indicated that when families wanted to remain together, they felt anxious about DCP or KWY learning about any risk in the home, often anticipated a

punitive response and so withheld information or minimised the violence. Overall, any attempts to separate family members did not reduce risk. Instead, the fear of separation led to the families hiding risk or added additional stress placed on the mother. In this case analysis, all the families remained together, regardless of the decisions made by either DCP or KWY. This was particularly challenging as it was often the perpetrator who disengaged from services, with KWY and DCP continuing to work with the mother.

In closing, collaboration is not a new concept, and research has demonstrated that collaboration facilitates shared understandings or knowledge about "the dynamics and impacts of domestic and family violence and operationalisation of core concepts such as safety, risk, and accountability" (Bastian & Wendt, 2023, p.2). These important elements were included in the prototype and enabled focused and deliberate discussion on issues such as risk assessments, safety planning and ongoing intervention and enabled shared language and focus on the perpetrator of violence. The prototype enabled KWY to ask questions, seek information and promote cultural understandings in a more active way. This project also found that the prototype was dependent on relationships and the building of respect and trust for it to come to fruition. Collaboration is fundamentally relational where shared decision making, sharing of information, and shared intervention approaches are contingent on communication across the two sectors focus on achieving the safety and wellbeing of children and their families.

Conclusion and Recommendations

This report has provided an overview of the establishment and implementation of the collaborative service response between KWY and DCP by building a prototype to enable this practice. Finding have been presented across all phases of the project including establishing the authorising environment, observing case conferences, and interviewing families who were recipients of service provision by DCP and KWY simultaneously. This final report of the collaboration between KWY and DCP is the culmination of more than two years work in the collection and analysis of data.

The central question that needs to be answered – *Did the prototype or the collaborative service response make a difference to practice at the intersection of domestic and family violence and child protection? Who benefitted the most from the prototype?*

- Both agencies demonstrated commitment and enthusiasm in the development and implementation of the prototype which had benefits in developing professional alliances and understandings about organisational practices, policies and operations. High level investment in time and communication activities were necessary to ensure all staff in the Southern Metropolitan offices were aware of the prototype and required processes which, at times, hampered the implementation process. This was further exacerbated by high staff turnover particularly in DCP.
- The prototype co-designed by practitioners from KWY and DCP in the context of an authorising environment provided a structured process for collaboration identifying key elements including referral pathways, sharing of information, case discussions and case reviews, shared decision making, and communication pathways.

An embedded structure was informed by practice principles and theoretical foundations, providing clarity of expectations, roles and responsibilities for the practitioners in KWY and DCP. The co-design process and case discussions facilitated respectful working alliances, institutional empathy and improved communication. The prototype had direct benefits for the families as DCP were provided with holistic assessments informed by the cultural and family violence expertise provided by KWY. Families identified that KWY supported them to understand DCP decision making and processes impacting on their lives that facilitated improved understanding of the statutory organisational mandate and facilitated improved engagement.

- The prototype facilitated a shift in language about family violence that informed a trauma understanding and response, where the perpetrator and his pattern of behaviours were up front and central in discussions, and in doing so, informed case direction and the necessary interventions. The impact of the violence on the victim parent was also discussed, however, the children were less visible. This can be explained by the fact that most of the children in this sample were in alternative care for most of the intervention and that KWY did not have a children's worker available during implementation and the data collection period. It is well known that change in families is predominantly operationalised through intervention with parents or family which has direct safety and wellbeing outcomes for children. Having said this, of the six families, four of the families continued to care for their children or were reunified and two families had children who were either removed or placed in care.
- The prototype was culturally responsive and culture was centrally situated in most discussions between practitioners. Being culturally responsive was informed by the inclusion of Aboriginal practitioners in the authorising environment and all case discussions and case reviews ensuring that Aboriginal knowledge and expertise was privileged. These processes enabled a culturally safe space where sustainable relationships were developed, which was evidenced through shared understanding and accountability between the agencies which, in turn, redressed the inequality, oppression towards respect for Aboriginal ways of workings. KWY is an Aboriginal Community Controlled Organisation and working alongside Aboriginal families had direct and positive impact for families where they felt valued, listened to, and in some circumstances strengthened their connection to culture. However, some of the families identified that DCP did not understand their experiences of trauma and how this has impacted on them, their parenting, and ability to keep their children safe.
- A unique feature of the prototype was the Specialist Liaison Officer (SLO) who provided a strategic and deliberate link between the two agencies that benefitted all practitioners and families. The SLO was responsible for the implementation of the prototype and key elements, building professional relationships, enabled cross system information sharing and communication, and appropriate management of cases. The SLO also identified any system barriers which were then communicated to the working group and senior advisory group. The employment of an SLO as part of the collaborative service proved to be an inexpensive solution to linking services enhancing collaboration to the benefit of both practitioners and families.

- A significant feature of the prototype was that information and decision making was to be shared. There were challenges identified in relation to these elements of the prototype because DCP were more inclined to quote legislation as the final say, which challenged the ethos of the collaboration.

In conclusion there are clear benefits that emerged from using the prototype for 2 years but also key challenges. As noted earlier, collaboration is identified as an effective way of ensuring effective multi-agency service provision to children, young people and their families who experience complexity and the findings of the project showed aspects of practice that were beneficial for practitioners and family outcomes. A challenge though is to keep the time, energy and momentum for collaboration and investment in mechanisms such as the prototype and SLO's to maintain sustainable and influential collaboration in practice change over time.

The following recommendations can be made:

1. That DCP, in collaboration with KWY, review the prototype and consider embedding it across the organisation inclusive of communication and evaluation.
2. That consideration be given to funding SLO's across the regions of DCP to facilitate full implementation of the prototype.
3. That DCP consider that the prototype be extended so that KWY and other Aboriginal practitioners be involved in the investigation and assessment phase of the child protection process to reduce the likelihood of Aboriginal children entering into out of home care.
4. That DCP and KWY engage in further discussions to clearly understand how to effectively share risk and power so that decision-making and information sharing is truly collaborative and informed by domestic and family violence lens and cultural expertise.
5. Enhance the visibility and inclusiveness of children and young people in discussions of collaboration.

References

AIHW. (2023). *Child protection Australia 2021–22* (Vol. Table). https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2021-22/contents/about

Baidawi, S., Mendes, P., & Saunders, B. J. (2017). The complexities of cultural support planning for Indigenous children in and leaving out-of-home care: the views of service providers in Victoria, Australia. *Child & Family Social Work*, *22*(2), 731-740.

Banks, D., Dutch, N., & Wang, K. (2008). Collaborative Efforts to Improve System Response to Families Who Are Experiencing Child Maltreatment and Domestic Violence. *23*(7), 876-902. https://doi.org/10.1177/0886260508314690

Banks, D., Landsverk, J., & Wang, K. (2008). Changing policy and practice in the child welfare system through collaborative efforts to identify and respond effectively to family violence [Article]. *Journal of Interpersonal Violence*, *23*(7), 903-932. https://doi.org/10.1177/0886260508314693

Bastian, C., & Wendt, S. (2023). Collaboration Between child protection and domestic and family violence: A case file review. *Australian Social Work*, *76*(2), 186-202. https://doi.org/10.1080/0312407X.2021.2000627

Benington, J., & Moore, M. H. (2011). Public value in complex and changing times. In *Public Value* (pp. 1-30). Springer.

Blagg, H., Bluett-Boyd, N., & Williams, E. (2015). *Innovative models in addressing violence against Indigenous women: state of knowledge paper*. Australia's National Research Organisation for Women's Safety.

Commonwealth of Australia. (2017). *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing*. Department of the Prime Minister and Cabinet. https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf

Commonwealth of Australia. (2022). *National plan to end violence against women and children*. https://www.dss.gov.au/sites/default/files/documents/11_2022/national_plan_to_end_violence_against_women_and_children_2022-2032.pdf

Connolly, M., Humphreys, C., & Healey, L. (2017). *The Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: The PATRICIA Project: Key Findings and Future Directions*.

Cripps, K., & Adams, M. (2014). Family violence: Pathways forward. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed.). Commonwealth of Australia. https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-5-chapt-23-final.pdf

Cripps, K., & McGlade, H. (2008). Indigenous family violence and sexual abuse: Considering pathways forward. *Journal of Family Studies*, *14*(2-3), 240-253.

Dudgeon, P., & Walker, R. (2015). Decolonising Australian Psychology: Discourses, Strategies, and Practice. *Journal of Social and Political Psychology*, *3*(1), 276-297. https://doi.org/10.5964/jspp.v3i1.126

Family Matters. (2019). *The Family Matters report 2019*. https://www.familymatters.org.au/wp-content/uploads/2020/02/1097_F.M-2019_LR.%C6%92updated.pdf

Friedman, S. R., Reynolds, J., Quan, M. A., Call, S., Crusto, C. A., & Kaufman, J. S. (2007). Measuring changes in interagency collaboration: An examination of the Bridgeport Safe Start Initiative. *Evaluation and Program Planning*, *30*(3), 294-306. https://doi.org/https://doi.org/10.1016/j.evalprogplan.2007.04.001

Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2013). Aboriginal and Torres Strait Islander social and emotional wellbeing and mental health. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, 55-68.

Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Social and emotional wellbeing and mental health: an Aboriginal perspective. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, 55-68.

Geia, L. K., Hayes, B., & Usher, K. (2011). A strengths based approach to Australian Aboriginal childrearing practices is the answer to better outcomes in Aboriginal family and child health. *Collegian*, *18*(3), 99-100.

Geia, L. K., Hayes, B., & Usher, K. (2013). Yarning/Aboriginal storytelling: Towards an understanding of an Indigenous perspective and its implications for research practice. *Contemporary nurse*, *46*(1), 13-17.

Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey-Bass/Wiley.

Harris, P. A., Taylor, R., Thielke, R., Payne, J., Gonzalez, N., & Conde, J. G. (2009). Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics*, *42*(2), 377-381. https://doi.org/https://doi.org/10.1016/j.jbi.2008.08.010

Hartley, J., Alford, J., Knies, E., & Douglas, S. (2017). Towards an empirical research agenda for public value theory. *Public Management Review*, *19*(5), 670-685.

Humphreys, C., & Healey, L. (2017). *PAThways and Research Into Collaborative Inter-Agency practice: collaborative work across the child protection and specialist domestic and family violence interface: the PATRICIA Project. Final report*. ANROWS.

Indigenous Allied Health Australia. (2015). *Cultural responsiveness framework*. https://iaha.com.au/workforce-support/training-and-development/cultural-responsiveness-in-action-training/

Laing, L., Heward-Belle, S., & Toivonen, C. (2018). Practitioner Perspectives on Collaboration across Domestic Violence, Child Protection, and Family Law: Who's Minding the Gap? *Australian Social Work*, *71*(2), 215-227. https://doi.org/10.1080/0312407X.2017.1422528

Lalayants, M. (2008). Bridging disciplines in child protection: Guidelines for successful collaboration [Article]. *International Journal of Interdisciplinary Social Sciences*, *2*(5), 147-155. https://www.scopus.com/inward/record.uri?eid=2-s2.0-79952478610&partnerID=40&md5=54347c59b794f3a0ddd4ba335db514d3

Langenderfer-Magruder, L., Alven, L., Wilke, D. J., & Spinelli, C. (2019). “Getting Everyone on the Same Page”: Child Welfare Workers’ Collaboration Challenges on Cases Involving Intimate Partner Violence [Article]. *Journal of Family Violence*, *34*(1), 21-31. https://doi.org/10.1007/s10896-018-0002-4

Lohoar, S., Butera, N., & Kennedy, E. (2014). Strengths of Australian Aboriginal cultural practices in family life and child rearing.

Lovett, R., & Olsen, A. (2016). *Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge paper*. ANROWS.

Moore, J., Wendt, S., Rigney, C., & Bastian, C. (2023). Aboriginal Cultural Safety: A Case Study of Collaborative Practice at the Intersection of Family Violence and Child Protection. *Australian Social Work*, *76*(2), 203-216. https://doi.org/10.1080/0312407X.2022.2078220

Moore, M. H. (1995). *Creating public value: Strategic management in government*. Harvard University Press.

Moore, M. H. (2013). *Recognizing Public Value*. Harvard University Press.

Moore, T. (2014). Using place-based approaches to strengthen child wellbeing. *Developing Practice: The Child, Youth and Family Work Journal*(40), 40-52.

Moore, T., & Fry, R. (2011). Place-based approaches to child and family services: A literature review. *Parkville, Victoria: Murdoch Childrens Research Institute and The Royal Children's Hospital Centre for Community Child Health*.

Nyland, M. (2016). *Child protection systems royal commission report: Volume 1: Summary and report*. Government of South Australia. https://www.childprotection.sa.gov.au/documents/report/child-protection-systems-royal-commission-report.pdf

O'Leary, P., Young, A., Wilde, T., & Tsantefski, M. (2018). Interagency Working in Child Protection and Domestic Violence. *Australian Social Work*, *71*(2), 175-188. https://doi.org/10.1080/0312407x.2017.1422773

Our Watch. (2018). *Changing the picture*. Our Watch. https://media-cdn.ourwatch.org.au/wp-content/uploads/sites/2/2020/09/20231759/Changing-the-picture-Part-2-AA.pdf

Productivity Commission. (2023). *Report on government services 2023*. Australian Government. Retrieved 6 July from https://www.pc.gov.au/ongoing/report-on-government-services/2023/community-services/child-protection

Scott, D. (2005). Inter-organisational collaboration in family-centred practice: A framework for analysis and action. *Australian Social Work*, *58*(2), 132-141.

Segal, L., Nguyen, H., Mansor, M. M., Gnanamanickam, E., Doidge, J. C., Preen, D. B., Brown, D. S., Pearson, O., & Armfield, J. M. (2019). Lifetime risk of child protection system involvement in South Australia for Aboriginal and non-Aboriginal children, 1986–2017 using linked administrative data. *Child Abuse & Neglect*, *97*, 104145. https://doi.org/10.1016/j.chiabu.2019.104145

South Australian Department for Child Protection. (2021). *Aboriginal Action Plan*. https://www.childprotection.sa.gov.au/department/about-us/aboriginal-action-plan

Stanley, N., & Humphreys, C. (2014). Multi-agency risk assessment and management for children and families experiencing domestic violence. *Children and Youth Services Review*, *47*(P1), 78-85. https://EconPapers.repec.org/RePEc:eee:cysrev:v:47:y:2014:i:p1:p:78-85

Stanley, N., & Humphreys, C. (2017). Identifying the key components of a 'whole family'intervention for families experiencing domestic violence and abuse. *Journal of gender-based violence*, *1*(1), 99-115.

Tarzia, L., Humphreys, C., & Hegarty, K. (2017). Translating research about domestic and family violence into practice in Australia: possibilities and prospects. *Evidence and policy*, *13*(4), 709-722.

Thomson, A. M., & Perry, J. L. (2006). Collaboration Processes: Inside the Black Box. *Public Administration Review*, *66*(s1), 20-32. https://doi.org/https://doi.org/10.1111/j.1540-6210.2006.00663.x

Thomson, A. M., Perry, J. L., & Miller, T. K. (2009). Conceptualizing and measuring collaboration. *Journal of Public Administration Research and Theory*, *19*(1), 23-56.

Trute, B., & Hiebert-Murphy, D. (2013). 4 Fundamentals of Working Alliance. *Partnering with Parents: Family-centred Practice in Children's Services*, 68.

Tsantefski, M., Wilde, T., Young, A., & O'Leary, P. (2018). Inclusivity in Interagency Responses to Domestic Violence and Child Protection. *Australian Social Work*, *71*(2), 202-214. https://doi.org/10.1080/0312407X.2017.1422775

Turnell, A., & Murphy, T. (2017). *Signs of Safety Comprehensive Briefing Paper* (Fourth ed.). Elia International Ltd.

Warshaw, C., Rivera, E. A., & Sullivan, C. M. (2013). A systematic review of trauma-focused interventions for domestic violence survivors.

Wendt, S., Bastian, C., & Jones, M. (2021). Building collaboration with child protection and domestic and family violence sectors: Trialling a living lab approach. *The British Journal of Social Work*, *51*(2), 692-711.

Wilson, J. M., Fauci, J. E., & Goodman, L. A. (2015). Bringing trauma-informed practice to domestic violence programs: A qualitative analysis of current approaches. *American Journal of Orthopsychiatry*, *85*(6), 586.

Yin, R. K. (1992). The case study method as a tool for doing evaluation. *Current sociology*, *40*(1), 121-137.

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage.

Appendix One

BA Family

The victim parent and perpetrator had four children aged 15 years, 11 years, 9 years, and 7 years. The perpetrator was charged after driving while intoxicated and was incarcerated soon after the warm referral to KWY.

Precipitating incident for DCP and KWY involvement

DCP became involved near the end of 2018 when the perpetrator had a car accident while intoxicated. The 7-year-old child was in the front seat and received a head laceration after being thrown through the windscreen, requiring surgery. The perpetrator may have assaulted the 7-year-old child while he was in the hospital, but no further information was provided. At this time, DCP arranged for the children to live with their maternal grandparents on a safety plan for two weeks.

The case was closed with high risk but the children safe with the grandparents. However, there was then a notification that the 11-year-old child was sexually abused by the grandfather's employer while in the home of the paternal grandparents. SAPOL were unable to press charges because the child was too emotionally dysregulated to be a 'credible witness' in court.

History

There was a 14-year history of child protection concerns describing an unclean home due to the perpetrator's hoarding, neglect, violence in the home, the perpetrator using harsh discipline, and methamphetamine use by both parents. There was also a history of poor school attendance and a report that the perpetrator assaulted the children while at a bus stop.

When services, such as Child Wellbeing Practitioners, were provided to the family, the perpetrator refused to let them in the home. He typically used violence such as destroying property, controlling the family finances, and locking the children or the victim parent in the house. He was frequently violent towards the victim parent and would slap her and threaten to take the children away if she tried to leave him. The victim parent once tried to leave the perpetrator but returned after he threatened to kill himself. The victim parent's family historically cared for the children during times when the parents were unable. The extended family even purchased a home for the family to live in.

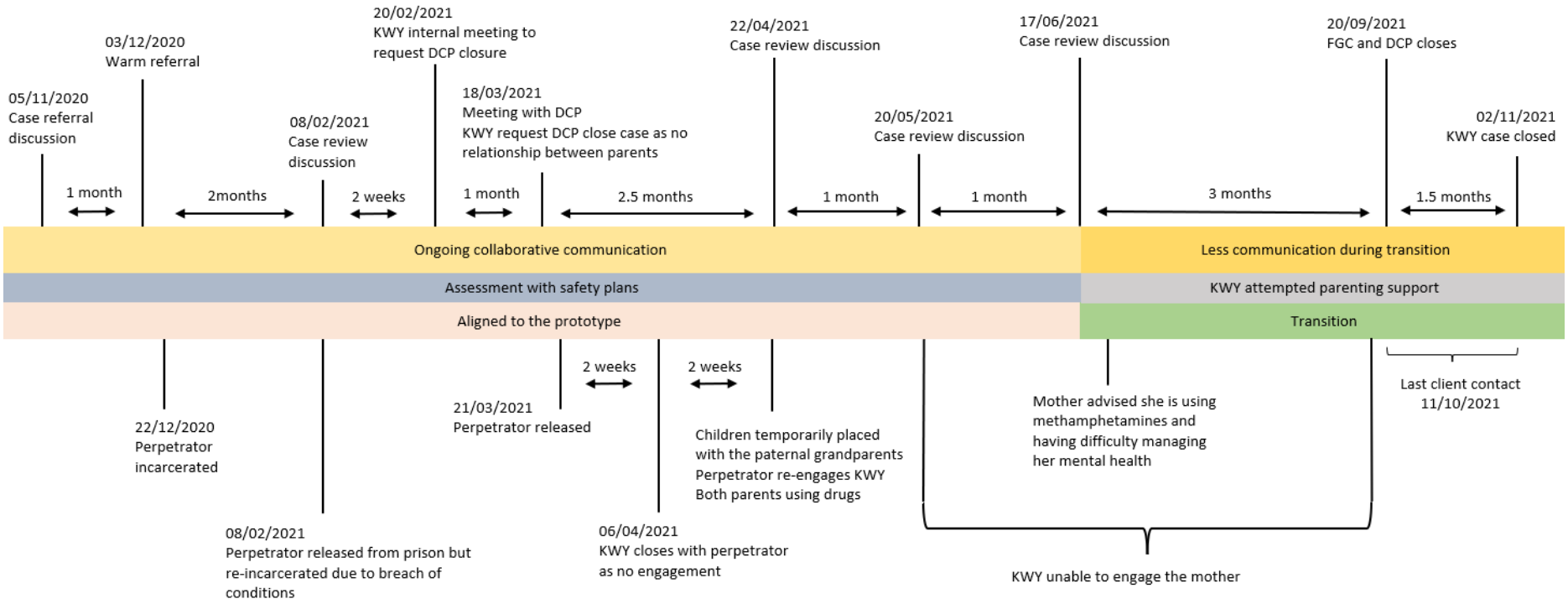
Interventions and progress across the case discussions

At the start of the intervention, the victim parent appeared to be a protective parent. The perpetrator was arrested for assaulting the 7-year-old child, and the victim parent took full care of the children. However, the victim parent began using methamphetamines, possibly after the perpetrator was released. She also took in two homeless men, who lived in the backyard, and the children reported she was using methamphetamines with them. The

mother advised that she was having difficulty managing her mental health. The children reported that they did not want to live with her.

After his release from prison, the perpetrator remained clean from methamphetamines. Initially, he showed stalking behaviours, visiting the victim parent late at night and getting the children to let him in. Later, the perpetrator showed more stability in his behaviours and the children stated that they wanted to live with him. The perpetrator then took sole care of the children.

By the final case discussion, the parents had moved in together and were co-parenting. The perpetrator retained his own home to help relieve stress when needed. The children were regularly attending school and there were no concerns for them. There did not appear to be ongoing DFV but still poor relationship skills. KWY reported limited engagement from either parent. A family group conference was held and both DCP and KWY closed the case.


05/11/2020
Case referral discussion
03/12/2020
Warm referral
08/02/2021
Case review discussion
20/02/2021
KWY internal meeting to request DCP closure
18/03/2021
Meeting with DCP
KWY request DCP close case as no relationship between parents
22/04/2021
Case review discussion
20/05/2021
Case review discussion
17/06/2021
Case review discussion
20/09/2021
FGC and DCP closes
02/11/2021
KWY case closed
1 month
2months
2 weeks
1 month
2.5 months
1 month
1 month
3 months
1.5 months
Ongoing collaborative communication
Less communication during transition
Assessment with safety plans
KWY attempted parenting support
Aligned to the prototype
Transition
22/12/2020
Perpetrator incarcerated
08/02/2021
Perpetrator released from prison but re-incarcerated due to breach of conditions
21/03/2021
Perpetrator released
2 weeks
2 weeks
06/04/2021
KWY closes with perpetrator as no engagement
Children temporarily placed with the paternal grandparents
Perpetrator re-engages KWY
Both parents using drugs
Mother advised she is using methamphetamines and having difficulty managing her mental health
Last client contact
11/10/2021
KWY unable to engage the mother

JT Family

The victim parent and perpetrator had one child. The child was removed by DCP at birth and was 4-weeks-old at the start of the intervention. By the last case discussion, the child was nine-months-old with a decision made for long-term orders.

Precipitating incident for DCP and KWY involvement

DCP became involved during the pregnancy and removed the child at birth. At this time, both parents were both using methamphetamines and heroin and had no stable accommodation. When the victim parent found out she was pregnant, she and the perpetrator contacted DASSA. The perpetrator went onto methadone and the victim parent onto suboxone.

Even after the child was removed there was ongoing violence. When visiting the home, a DCP social worker witnessed the perpetrator throw a glass at neighbour and start hitting him with his fists. The perpetrator minimised the incident and forced the victim parent to speak as a witness despite her not being present.

History

The victim parent had a history of being sexually abused by her grandfather. At the time of the intervention, she was going through a court process regarding the abuse. All of her siblings had their children living in OOHC. One of the siblings was part of the Royal Commission into Institutional Abuse, speaking about his experience as a victim.

The perpetrator disclosed being childhood sexual abuse by his mother's partner. There was medical information stating that he had a head injury, but the cause was unclear. The perpetrator was known to carry a pocketknife for his own protection as he felt paranoid around others.

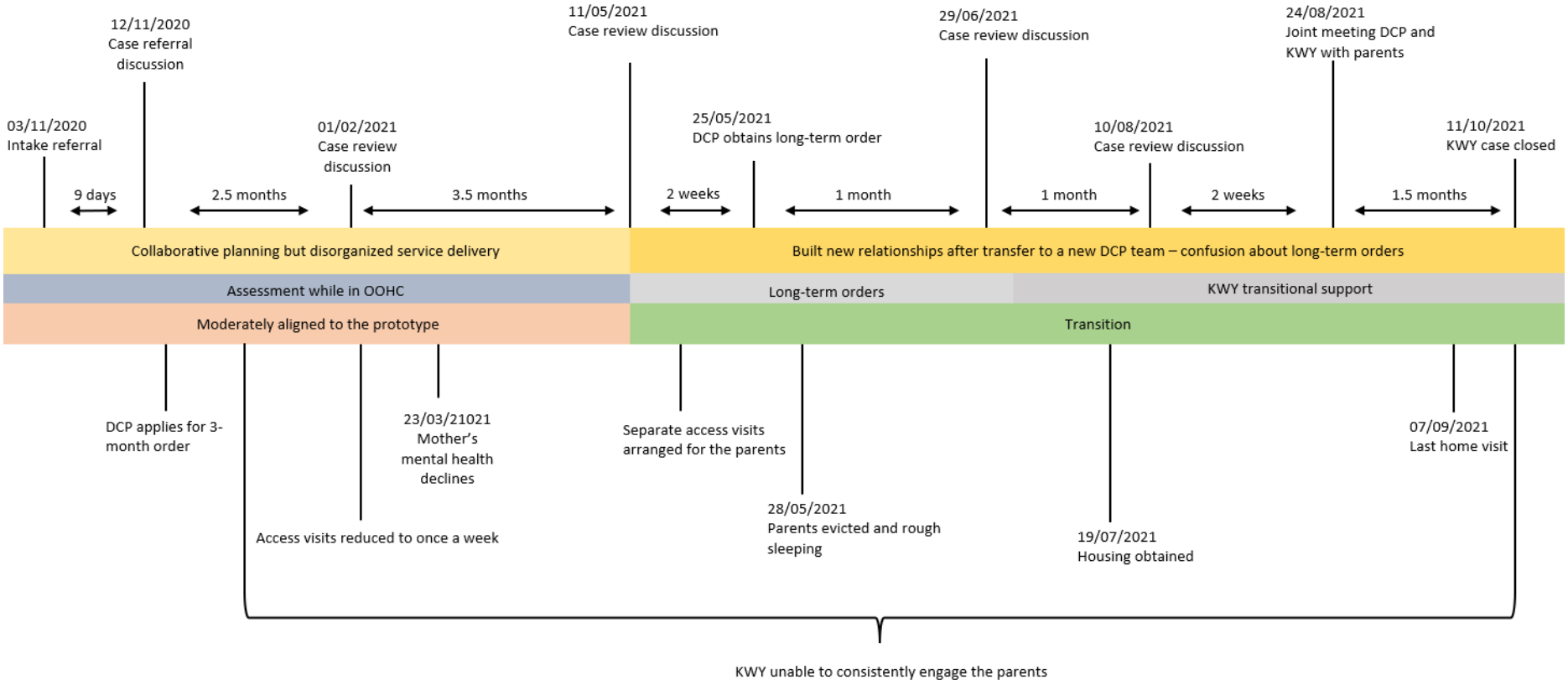
There was also a history of DFV. The perpetrator used controlling behaviour towards the victim parent, for example, speaking for her when engaging with any services and not letting her attend any events on her own. The perpetrator also assaulted the victim parent by putting her in a headlock and giving her a black eye. The perpetrator had two prior intervention orders placed on him by other partners. He also had a history of heroin and methamphetamine use.

Interventions and progress across the case discussions

The parents were supported individually, with the victim parent engaged in a women's group. KWY noted that the victim parent appeared happier and more open. Despite this positive, the parents remained in a relationship, and it was difficult to contact them for appointments. They were also very inconsistent during contact visits with their child and regularly had excuses for not attending. Their relationship remained and the perpetrator forced the victim parent out of the home several times.

Housing was an ongoing issue, with the parents living with family friends of community supports. During the intervention, the parents obtained long-term housing their engagement with services improved significantly, however long-term orders had already been sought. The parents frequently made comments to suggest they thought the child would be returned to them and there was concern that they did not understand the orders.

DCP struggled to engage with the parents. Ultimately, no reunification plan was considered, and the child went directly from a three-month assessment order to long-term orders. The child was placed with kinship carers in Queensland.


03/11/2020
Intake referral
12/11/2020
Case referral discussion
01/02/2021
Case review discussion
11/05/2021
Case review discussion
25/05/2021
DCP obtains long-term order
29/06/2021
Case review discussion
10/08/2021
Case review discussion
24/08/2021
Joint meeting DCP and KWY with parents
11/10/2021
KWY case closed
9 days
2.5 months
3.5 months
2 weeks
1 month
1 month
2 weeks
1.5 months
Collaborative planning but disorganized service delivery
Built new relationships after transfer to a new DCP team – confusion about long-term orders
Assessment while in OOHC
Long-term orders
KWY transitional support
Moderately aligned to the prototype
Transition
DCP applies for 3-month order
Access visits reduced to once a week
23/03/21021
Mother's mental health declines
Separate access visits arranged for the parents
28/05/2021
Parents evicted and rough sleeping
19/07/2021
Housing obtained
07/09/2021
Last home visit
KWY unable to consistently engage the parents

MC Family

The mother had six children in total. The first four were fathered by a previous partner and aged 18 years, 17 years, 16 years, and 15 years. The mother then re-partnered with a 19-year-old male who was a friend of her son. They had a two-year-old child together and, at the time DCP became involved, the mother was pregnant with another child.

Precipitating incident for DCP and KWY involvement

No incident was identified; however, ongoing violence was described amongst the parents and the older children. Rather than domestic violence, DCP identified their concern as family violence, with no parent willing or able to protect the children. This violence included physical blows, verbal fights, and the father trying to cut his own throat with broken glass due to distress.

History

The mother had an extensive history of child protection concerns in multiple states. She was in a relationship with a previous partner who used violence. The mother was diagnosed with bipolar personality disorder and used physical violence and control against the father. The mother also used harsh physical discipline with the children.

The father identified a history of being sexually abused as a child.

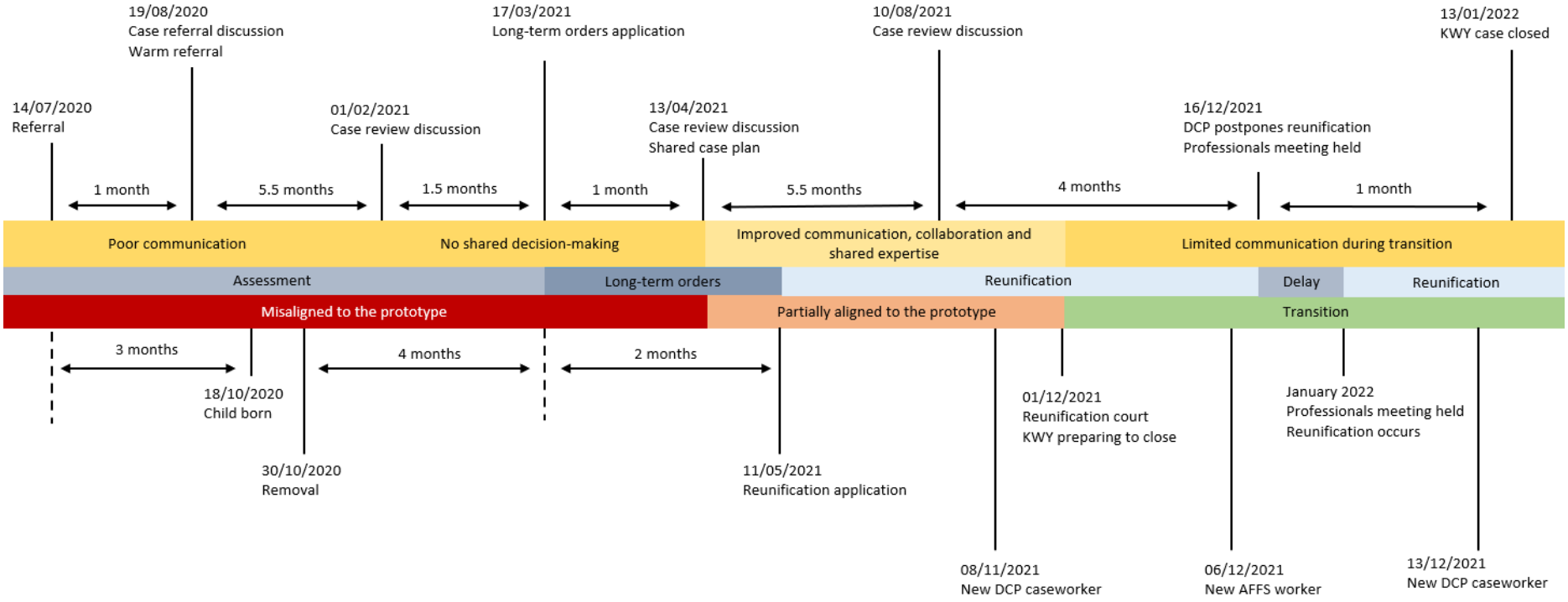
Intervention and progress during the case discussions

The mother engaged well with KWY, attending multiple groups and programs. Contact visits were positive and held three times a week. However, the mother did not have a good relationship with DCP and was verbally abusive to staff.

Across the case discussions, the parents engaged well with KWY and put in more boundaries with the older children. The mother showed insight into the needs of the younger children and was emotionally connected to them.

Between the first and second case review discussions, DCP applied for long-term orders. KWY and the parents were surprised by this case direction, given the good engagement reported by service providers. During the second case review discussion, KWY advocated for the family and, together with the DCP PAC, explained the impact of intergenerational cultural trauma on the parents. One month later, DCP applied for reunification based on the high level of evidence and support from various service providers. No further case discussions were held, however the case remained open for a further five months before KWY closed. During this time, reunification was delayed as the older behaviours of the children were still a concern. There were many changes of DCP and Aboriginal Family Support Service (AFSS) staff and unclear communication between the organisations. A professionals meeting was held but there was no clear outcome. One of the older children was instructed to leave the home as part of a safety plan. A second professionals meeting was held and the DCP director became

involved to finalise the decision. Ten months after DCP advised of their case direction changing to long-term guardianship, the orders were revoked, and the children reunified.


14/07/2020
Referral
19/08/2020
Case referral discussion
Warm referral
01/02/2021
Case review discussion
17/03/2021
Long-term orders application
13/04/2021
Case review discussion
Shared case plan
10/08/2021
Case review discussion
16/12/2021
DCP postpones reunification
Professionals meeting held
13/01/2022
KWY case closed
1 month
5.5 months
1.5 months
1 month
5.5 months
4 months
1 month
Poor communication
No shared decision-making
Improved communication, collaboration and shared expertise
Limited communication during transition
Assessment
Long-term orders
Reunification
Delay
Reunification
Misaligned to the prototype
Partially aligned to the prototype
Transition
3 months
4 months
2 months
18/10/2020
Child born
30/10/2020
Removal
11/05/2021
Reunification application
01/12/2021
Reunification court
KWY preparing to close
January 2022
Professionals meeting held
Reunification occurs
08/11/2021
New DCP caseworker
06/12/2021
New AFFS worker
13/12/2021
New DCP caseworker

PM Family

The perpetrator self-identified as a Ngangkari with high community status and the victim parent a Ngarrindjeri Pitjantjatjara woman. Together they had a 13-year-old child. The victim parent also had an adult daughter from a previous relationship. There were no orders on the child and instead he was living with his aunt under a family agreement. DCP did not refer the family and instead the referral came from another organisation.

Precipitating incident for DCP and KWY involvement

The child had been living with his maternal aunt for some time but there were concerns for him under her care. The aunt left the child in the care of her 20-year-old daughter for months at a time without providing financial support. The child had medical needs, was disconnected from his education, and the family had trouble retaining stable accommodation. The child then self-placed back in his mother's care, prompting DCP to ensure she could provide the necessary care.

History

The perpetrator had a history of yelling and physically abusing the victim parent. There was also a report that the perpetrator encouraged the child to hit the victim parent. The victim parent left the perpetrator and stayed in emergency accommodation until he obtained separate housing. They remained living within walking distance of each other.

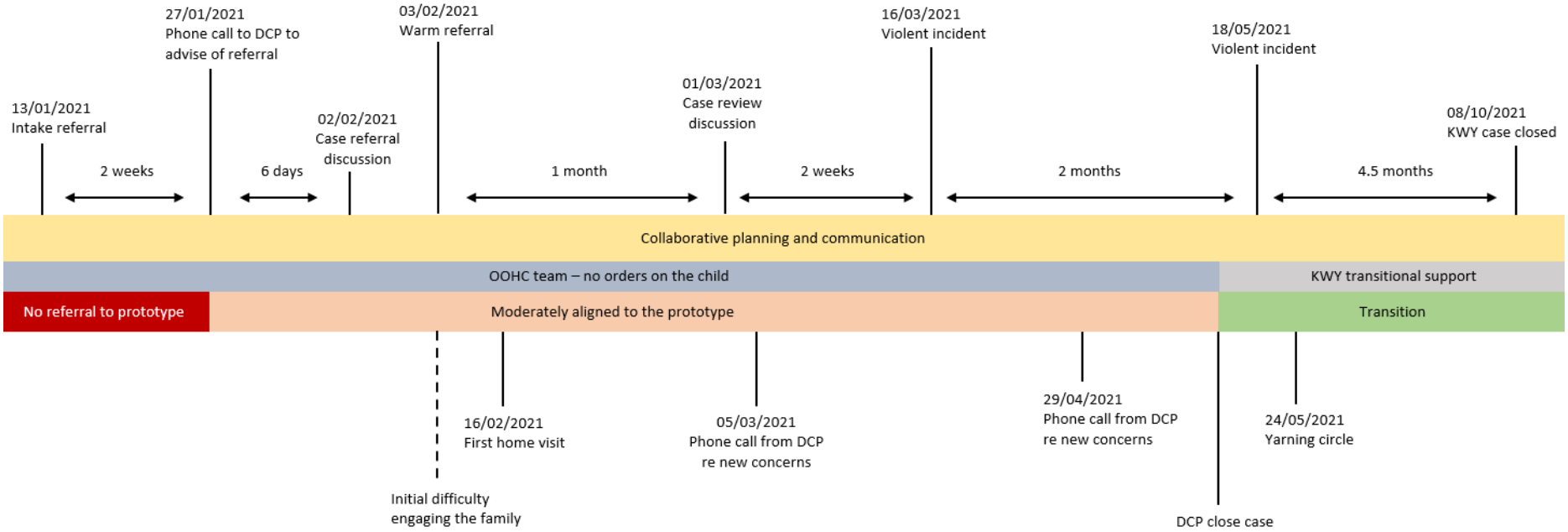
Intervention and progress during the case discussions

The goal at the first case discussion was to provide additional support to the victim parent to care for the child. The victim parent showed parenting capacity but there were concerns about her sustaining care for the child, especially as he grew older. There were general parenting concerns, for example, the child would often ask for money to buy Xbox games and then there would not be enough for food. The house was also unhygienic and in need of repair.

The victim parent engaged well with both DCP and KWY throughout the intervention period. She joined the women's group and received financial counselling and a KWY children's worker was assigned to support the child. The perpetrator did not engage and was regularly seen drunk at the property or verbally denigrating the victim parent. In one instance, the victim parent reported that the child physically pushed the perpetrator away to protect her. A yarning circle was held with the victim parent, the perpetrator, the child, and KWY staff. Here, the challenging behaviours of the child were discussed and the importance of all family members using the proper medication. The parents denied any yelling or fighting between them despite the child stating that he could not sleep at night because of the noise made by his parents.

The case was closed as the family no longer met eligibility criteria and had been working with the service past the provision period. At case closure, the victim parent had been referred to services for her mental health and substance misuse, but these had not commenced. The victim parent had applied for a housing transfer. The

child reported feeling sad and isolated. He was partially attending school, not taking his medication, and staying out late at night.


13/01/2021
Intake referral
2 weeks
27/01/2021
Phone call to DCP to advise of referral
6 days
02/02/2021
Case referral discussion
03/02/2021
Warm referral
1 month
01/03/2021
Case review discussion
2 weeks
16/03/2021
Violent incident
2 months
18/05/2021
Violent incident
4.5 months
08/10/2021
KWY case closed
Collaborative planning and communication
OOHC team – no orders on the child
KWY transitional support
No referral to prototype
Moderately aligned to the prototype
Transition
Initial difficulty engaging the family
16/02/2021
First home visit
05/03/2021
Phone call from DCP re new concerns
29/04/2021
Phone call from DCP re new concerns
DCP close case
24/05/2021
Yarning circle

RC Family

The parents had a daughter together, who was removed by DCP at birth. The daughter was placed with the paternal aunt while the parents worked towards reunification. The victim parent had older children not currently living with her.

Precipitating incident for DCP and KWY involvement

DCP became involved at the birth of the child due to concerns about substance use by both parents, DFV, and a child protection history for the victim parent's older children. It was assessed that the newborn would not be safe in the home.

History

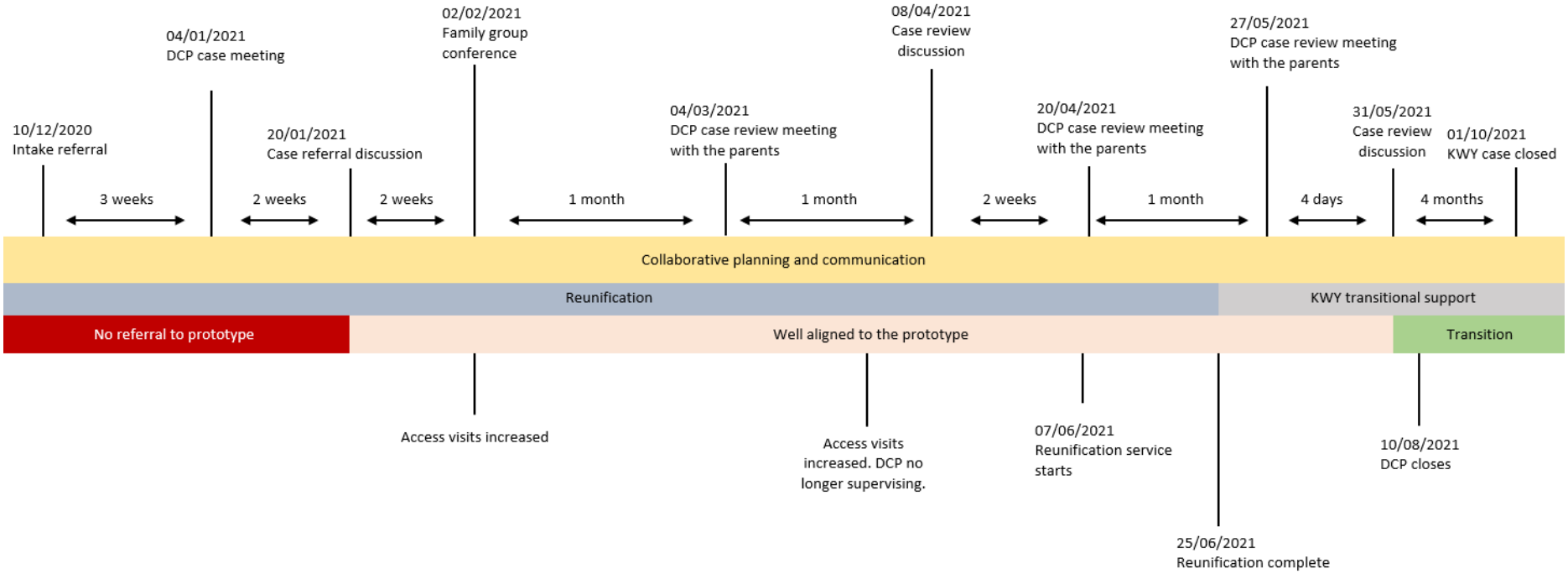
The perpetrator had a history of being violent towards previous partners and was named on an intervention order. He also had a history of criminal offences for driving infractions and substance misuse. The perpetrator overdosed on methamphetamines during the pregnancy and was admitted to hospital.

The perpetrator was verbally abusive towards the victim parent. One night he locked her out of the house while she was in her pyjamas and high on methamphetamines. The perpetrator was also reported to not let the Victim parent engage with services on her own and blocked her from receiving support while pregnant.

There was a child protection history for the Victim parent and concerns for her older children. There was also a report that the victim parent's older daughter physically assaulted the perpetrator during an altercation.

Interventions and progress across the case discussions

The parents appeared motivated and engaged throughout the intervention. They self-referred to KWY and immediately created a safety plan. All random drug screens were clean since the birth of the child. Once drugs were no longer impacting them, both the parents maintained a healthier relationship. Contact visits with the child were positive and transitioned to full days. The last KWY recorded home visit was prior to DCP case closure, however, KWY kept the service file open for another 4 months.


10/12/2020
Intake referral
3 weeks
04/01/2021
DCP case meeting
2 weeks
20/01/2021
Case referral discussion
2 weeks
02/02/2021
Family group conference
1 month
04/03/2021
DCP case review meeting with the parents
1 month
08/04/2021
Case review discussion
2 weeks
20/04/2021
DCP case review meeting with the parents
1 month
27/05/2021
DCP case review meeting with the parents
4 days
31/05/2021
Case review discussion
4 months
01/10/2021
KWY case closed
Collaborative planning and communication
Reunification
KWY transitional support
No referral to prototype
Well aligned to the prototype
Transition
Access visits increased
Access visits increased. DCP no longer supervising.
07/06/2021
Reunification service starts
25/06/2021
Reunification complete
10/08/2021
DCP closes

SK Family

The parents had two children, aged 2 years and 5 years. The victim parent had an older son who lived with relatives and thought the SK mother was his sister. The victim parent also had another child, who passed away. The perpetrator had an unnamed son placed on long-term orders. The perpetrator had no relationship with him.

Precipitating incident for DCP and KWY involvement

The information on the precipitating incident was unclear, however, there was information that the family house burnt down. Once DCP became involved there were further concerns. The perpetrator refused most drug tests and trimmed his body hair to make hair follicle testing impossible. The victim parent tested positive for methamphetamines.

History

There was an extensive interstate history prior to DCP involvement. He was diagnosed with schizophrenia, which often displayed as paranoia, and so he always carried a pocketknife for protection. On one occasion, the perpetrator choked the victim parent in front of the children and controlled the finances.

The perpetrator's parents have a child protection history, and the perpetrator was on a guardianship order as a child.

Interventions and progress across the case discussions

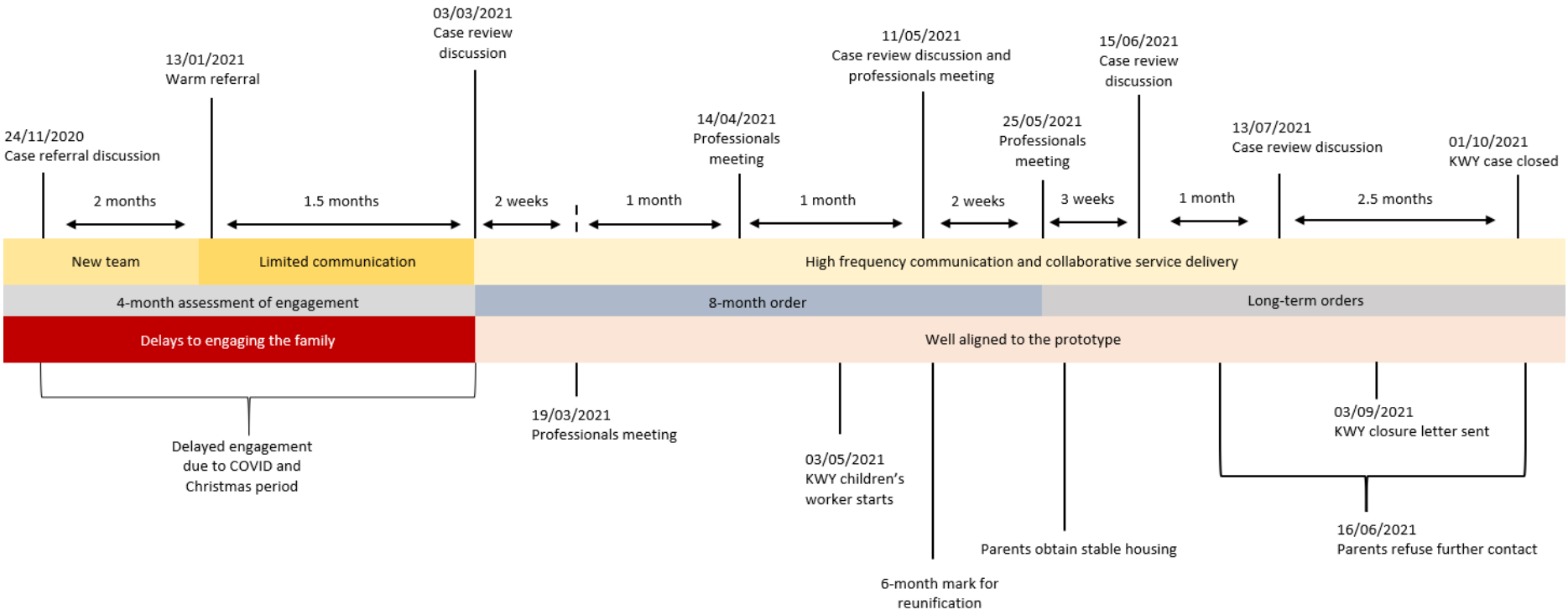
There was a delay to the start of support for the parents. Approximately two months passed between the case referral discussion and the warm referral with the parents. During this time, the DCP team holding the case also changed and not all of the information was available for case discussions. Because of these delays, KWY advocated for additional time to demonstrate parental capacity to change, and DCP agreed.

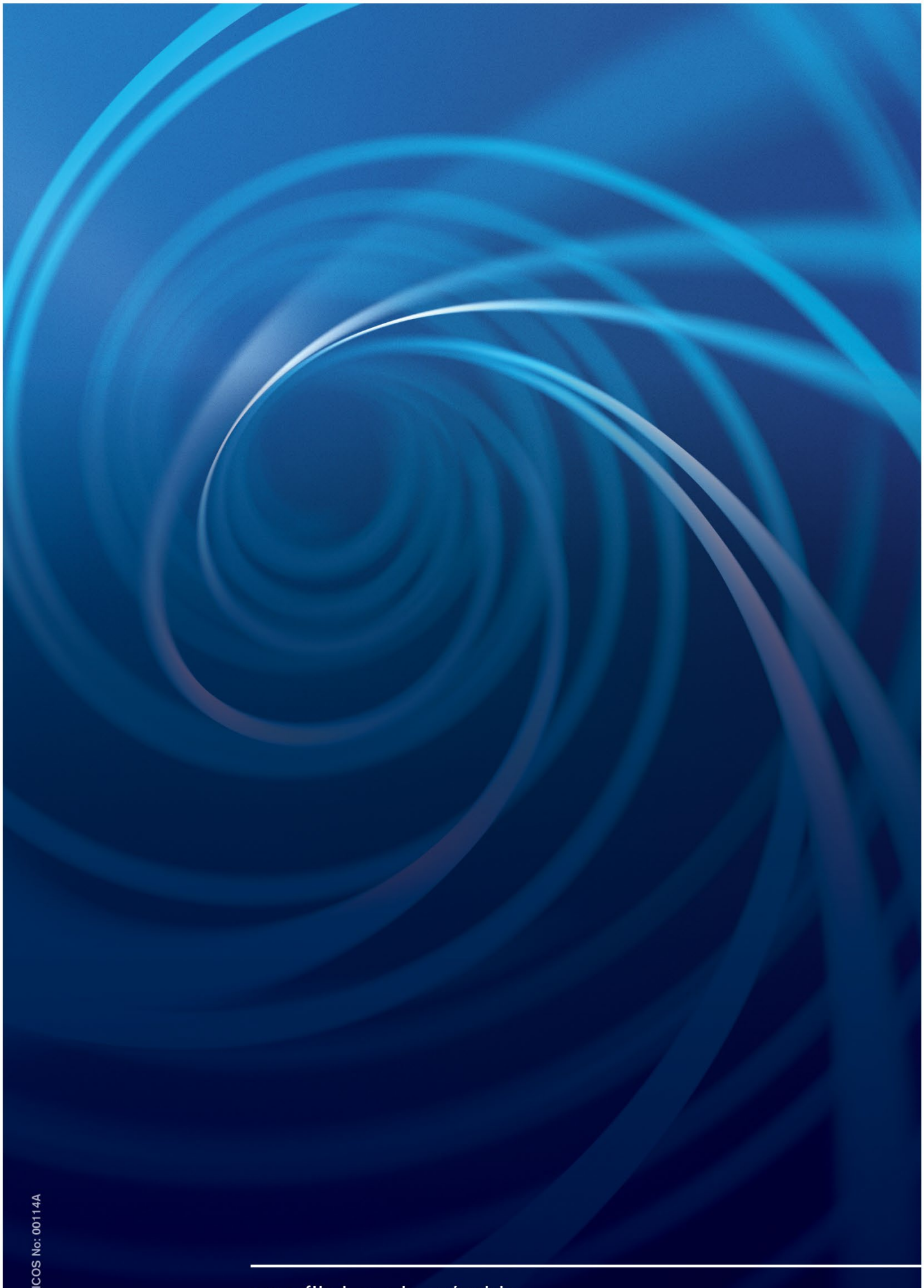
The parents were slow to engage with KWY. They often forgot conversations and there was difficulty communicating. As time went on, the perpetrator disengaged and stopped answering calls from KWY or other services. Later it was found out that the victim parent would not allow the perpetrator to have a phone because she did not trust him. The parents often missed access visits with their children due to not confirming that they would attend.

During the intervention period, the motel room where the parents were staying was found containing drug paraphernalia. When the motel room was discussed with the parents, the perpetrator walked out and refused to speak about it. When asked for a drug screen, the parents stated that they needed two weeks' notice. The parents were then evicted from the motel because of conflict with the neighbours and damaged property. On returning to their home, the level of clutter increased. The perpetrator started storing knives at the front door because he was afraid of conflict with his neighbours. Despite KWY having good conversations with parents

about engagement, they did not attend any appointments with services. The victim parent often reported that this was due to her poor health, which did not have a diagnosis but left her weak and nauseous.

Multiple professionals' meetings were held throughout the intervention. Because of the ongoing difficulties engaging the parents, Aboriginal Family Support Services closed their reunification support. DCP and KWY agreed to one more month of intensive support to assess whether reunification would still be viable. The family still did not engage and DCP decided to change the case direction to long-term guardianship.


24/11/2020
Case referral discussion
13/01/2021
Warm referral
03/03/2021
Case review discussion
14/04/2021
Professionals meeting
11/05/2021
Case review discussion and professionals meeting
25/05/2021
Professionals meeting
15/06/2021
Case review discussion
13/07/2021
Case review discussion
01/10/2021
KWY case closed
2 months
1.5 months
2 weeks
1 month
1 month
2 weeks
3 weeks
1 month
2.5 months
New team
Limited communication
High frequency communication and collaborative service delivery
4-month assessment of engagement
8-month order
Long-term orders
Delays to engaging the family
Well aligned to the prototype
Delayed engagement due to COVID and Christmas period
19/03/2021
Professionals meeting
03/05/2021
KWY children's worker starts
6-month mark for reunification
Parents obtain stable housing
03/09/2021
KWY closure letter sent
16/06/2021
Parents refuse further contact



www.flinders.edu.au/swirls

CRICOS No: 00114A

Appendix 3

Collaboration between

Women's Safety Services South Australia

and the

Department for Child Protection

Women's Safety Services SA

Government of South Australia | Department for Child Protection

Flinders UNIVERSITY | Social Work Innovation Research Living Space

Table of Contents

Acknowledgement

The collaborative service response must begin with an acknowledgement of the children and women who live with and experience domestic and family violence and come to the attention of child protection services.

The children and women who are recipients of the Department for Child Protection and Women's Safety Service SA are central to our work. Living in a context of violence bring them to the attention of services but should never diminish their dignity and humanity. Our primary mandate is to ensure that they are safe. In doing we join with them to harness their strength, resourcefulness, resilience and relationships so that they are free of violence. And, in doing so, hear their voice and learn what factors contribute to their ongoing safety and wellbeing. This collaborative service will ensure the safety of children and their mothers but also strives to enhance the visibility of the perpetrator and, where possible, engage him in ensuring safety of his family.

In the implementation of this collaborative service response there is a commitment to privilege Aboriginal knowledge and wisdom. Aboriginal child rearing and commitment to family and community is a protective mechanism. It is the intent of the researchers, in partnership with practitioners, to ensure that there is a socially just representation of Aboriginal people within all aspects of the research as a way of harnessing knowledge and wisdom and informing the development and implementation of service provision for Aboriginal and non-Aboriginal children, families and communities.

This collaborative service response has been informed by conversations with many staff from DCP and WSSSA. We would like to thank all the practitioners in who dedicated their precious time to speak with us towards to the development of this collaborative service response.

The specific details of this collaborative service response have been infused by the practice wisdom and enthusiasm of the practitioners who attended the co-design workshops. They are as follows:

Women's Safety Services SA

- Rachel Abdullah
- Megan Hughes
- Tiffany King
- Desarae Chandler

Department for Child Protection

- Dan Mitchell
- Janet Robson
- Rebecca James
- Colin Sparrow
- Hayley Stirling
- Gayle Bartlett
- Joyce Clark
- Bo Galant

- Angela Cameron
- Cathy Hickman
- Alan Wanganeen
- Julie Powell

- Jessica Talbot
- Cathy Hickman
- Victoria Driscoll
- Carmel Day

This is a living document and will evolve informed by practice-based research inclusive of practitioners, children and families and case file reviews.

This document has been written in consultation with practitioners in DCP and WSSSA by Professor Sarah Wendt, Dr Carmela Bastian, and Dr Jenny van der Arend from Social Work Innovation Research Living Space (SWIRLS) at Flinders University https://www.flinders.edu.au/swirls

If you have any questions please do not hesitate to contact us on [redacted]

Introduction

The Early Intervention Research Directorate (EIRD) aims to develop new strategies to better support vulnerable families and measure effectiveness of child protection initiatives. The lack of evidence-based practice at the intersection of domestic and family violence and child protection informs a practice-based research agenda to build collaborations across the Department for Child Protection and Women's Safety Services SA in the Southern Metropolitan region of Adelaide.

The impacts of domestic and family violence on women and children's lives has been established; and intersectional understandings of women and children lives across ethnicity, class, race, disability, sexuality, and rurality are being acknowledged as well as intersectional issues such as drug and alcohol addiction and mental health. Children and families who live in a context of complexity experience domestic and family violence, alcohol and drug abuse, mental health issues, homelessness, poor health outcomes and criminality. These factors contribute to significant trauma and require services that respond to crises and promote healing and recovery. Recent research (conducted by Professor Sarah Wendt, Dr Michelle Jones, and Dr Carmela Bastian) with Department for Child Protection and Women's Safety Services South Australia demonstrated that collaboration between domestic and family violence services and child protection systems is sometimes fraught and absent because of different organisational mandates and professionals operating from different paradigms. Specialist domestic violence services for women have emerged from the feminist movement and the understanding of domestic and family violence is grounded in gender-inequality. Consequently, practices focus on providing safety for female survivors/victims who experience trauma from predominantly male perpetrators (Hester, 2011). Children, although recognised, are not so prominent in the service provision of specialist domestic and family violence services (Moles, 2008). Child protection services focus on the paramount importance of children. Mothers are sometimes blamed and held to account for the children's safety whereas the fathers, as the main perpetrators of violence, are largely invisible (Hester, 2011; Humphreys & Absler, 2011). A lack of collaboration across sectors contributes to families being on a referral 'merry-go-around' and service responses that are predominantly driven by crisis response. Practitioners expressed that there is an absence of long-term interventions that are trauma and violence informed. Trauma informed approaches to domestic and family violence was identified by all practitioners who participated in this study.

The difficulties of managing complexity is a recurring theme (Wendt, Jones and Bastian, 2018). When domestic and family violence and child protection intersect, the challenges include risk management, uncertainty and volatility, particularly when families want to remain together. This complexity is further exacerbated by the presence of drug and alcohol misuse and mental health issues. Without understanding how domestic and family violence shapes or influences such intersectional problems, mothers and fathers can be positioned as passive in their parenting and therefore it becomes inevitable that child removal becomes the only option. There is an appetite nationally and locally to develop and adopt better collaborative and integrated service structures and practices that recognise and respond to child protection and domestic and family violence concerns. A number of states in

Australia have developed domestic and family violence policies and practice guidelines for child protection staff, which is helpful; however, there needs to be a greater focus on developing capacity for gender-sensitive, trauma-informed child safety responses if intervention goals are to be achieved. These collaborations have the potential for the development of joint risk assessment expertise, improve relationship building with families, increase capacity to understand and identify patterns of behaviour used by the perpetrator, recognising the impact of perpetrator behaviours on children and non-offending parents, and keeping him visible.

The policy landscape drives the imperative for collaborative service responses across the child protection and specialist domestic and family violence service sectors. Theoretically speaking, collaboration between these service sectors will improve effective responses and achieve positive outcomes for children and adults who experience domestic and family violence (Healey, Connolly, & Humphreys, 2018). Collaboration has the potential to improve outcomes for children and families who experience complex and intractable problems including domestic and family violence (McDonald & Rosier, 2011). Collaboration is a deliberate process towards improving the safety and wellbeing of children and women at the intersection of domestic and family violence and child protection (Blythe, Heffernan, & Walters, 2010). The process requires practitioners to work together across service sectors to ensure the safety of women and children and ensure that perpetrators are visible (Laing, 2003). There is a growing knowledge base about collaborative service responses across child protection and specialist domestic and family violence services (Stanley & Humphreys, 2017). However, there is limited understanding about the key practice strategies that are demonstrative of collaboration in this context of complexity.

Developing a stronger connection between child protection and domestic and family violence specialist services has not always been a priority because of historical tensions and organisational silos. Yet with clear governance, managerial commitment, and establishment of a learning culture, which is operationalised via specific and shared practical structures, resources and tools, collaboration can realistically make a difference. This collaborative service response also provides managerial staff and practitioners in DCP and WSSSA to build capacity, identify system gaps and opportunities to improve practice and improve outcomes for children and their families in South Australia.

Background and context

This collaborative service response has been funded by the Early Intervention Research Directorate (EIRD) in Department of Human Services. EIRD was established in line with recommendations made in the 2016 Child Protection Systems Royal Commission Report, The Life They Deserve. EIRD funded a Postdoctoral Fellowship Program which is supported by the infrastructure of the Social Work Innovation Research Living Space (SWIRLS) in the College of Education, Psychology and Social Work, at Flinders University. Professor Sarah Wendt, Associate Professor Lorna Hallahan, Dr Carmela Bastian and Dr Jenny van der Arend are working together with key stakeholders in the Department for Child

Protection and Women's Safety Services SA to co-design a collaborative response and develop understanding of 'what works' when responding to and supporting children and families experiencing domestic/family violence and child protection concerns.

The aims of the research project are as follows:

- Develop understanding about the specific ways in which children and families, who have multiple and complex needs, particularly domestic and family violence and child protection concerns navigate and interact the service systems
- Co-design, trial and test sustainable collaborations across the DCP and WSSSA so child and families can live positive lives
- Document and measure outcomes for children and families who receive services linked to the newly established collaborative across agency service response
- Identify practice-based evidence about strengths and service gaps towards the development of a more connected service system that facilitates the safety, healing and recovery of children and families
- Translate findings to inform workforce development within the sectors including understanding complexity and being trauma informed
- Consolidate practice-based research to inform the development of better services and a more connected service system for children and families

There will be a specific focus on culturally responsive service design and outcomes for Aboriginal children and families to facilitate their socio-emotional wellbeing. It is the intent of the researchers to ensure that there is a socially just representation of Aboriginal people within all aspects of the research. This is a way of harnessing their knowledge and wisdom and informing the implementation of service provision for Aboriginal and non-Aboriginal children, families and communities.

This project is an exciting opportunity to invest in better connected services that are responsive to the complexity that children and families experience. The knowledge generated from the practice research will support and inform the implementation of the new Child and Family Intensive Support System, Department of Human Services which is part of the South Australian Government's broader child protection reforms (https://dhs.sa.gov.au/__data/assets/pdf_file/0003/78870/Reform-Strategy-March-2019.PDF)

Definitions

The collaborative service response is focused on working with children and their families who experience domestic and family violence and child protection. To begin our work, we must have a shared understanding of domestic and family violence, risk and safety.

This is the beginning of a shared understanding and it will evolve as this collaboration is cemented in practice.

Domestic and Family Violence

Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children and can be both criminal and non-criminal. Domestic violence includes physical, sexual, emotional, and psychological abuse, isolating a woman from her family, friends, and community, and controlling the victims' access to finances.

There is significant evidence demonstrating that domestic and family violence is predominantly perpetrated by men against women and children. Coercive control and violence perpetrated by men is reflective of disrespect for women, intolerance and disregard for gender equality and the reinforcement of gender stereotypes and roles (WSSSA, 2019). The United Nations defines "violence against women as any act of gender-based violence that results in, or it likely to result in, physical, sexual or psychological harm or suffering to children, including threats of such acts, coercion or arbitrary deprivation of liberty" (Wendt and Zannatino, 2015, p. 2). Domestic violence is gender based and characterised by a pattern of violence coercive control and is considered by some authors as an act of intimate terrorism.

Children are also often exposed to the violence. The 2016 Personal Safety Survey undertaken by the Australian Bureau of Statistics (ABS) asked adults if any children in their care had seen or heard violence. One in 2 (50%, or 60,300) women who experienced violence from a current partner reported that children had seen or heard it. More than 2 in 3 (68%, or 418,000) women and 3 in 5 (60%, or 92,200) men who experienced violence from a previous partner also reported that children had seen it (AIHW, 2018, p. 71). Witnessing might mean seeing actual incidents of abuse, or intervening to stop the violence occurring (Campo, 2015). It can mean hearing threats or fighting noises from another room. Children may also observe the aftermath of physical abuse.

There is a large body of evidence to suggest that children who live in families where there is domestic and family violence are also more likely to experience other forms of child abuse, including neglect, and physical and sexual abuse (Tomison, 2000; Campo, 2015). Perpetrators may involve children in the violence as part of exercising their power and control (Campo, 2015). The stress of living with domestic and family violence can impact parental capacity to provide a safe and nurturing environment for children and result in neglect.

Aboriginal and Torres Strait Islander Family Violence

It is important to note that adopting a gender-based analysis is not always appropriate for Aboriginal and Torres Strait Islander women and their children. A gendered power analysis of violence predominantly focuses on the relationship between two people who are engaged in an intimate relationship. The term, 'family violence' is the most widely used term to identify the experiences of Aboriginal and Torres Strait Islander people, because it includes the broad range of marital and

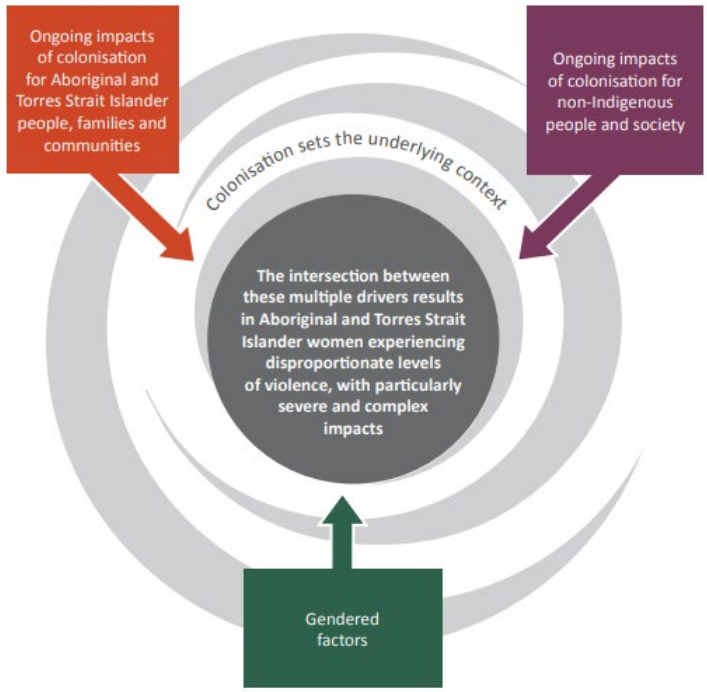
kinship relationships in which violence may occur. Family violence experienced by Aboriginal and Torres Strait Islander peoples is the cumulative impact of colonisation, dispossession of land, forced removal of children, interrupted cultural practices that mitigate against interpersonal violence, and economic exclusion contributing to cumulative intergenerational trauma. In the case of Aboriginal and Torres Strait Islander women, it is the intersection of gender and racial inequality that creates the conditions of such high rates of violence against them.

"Violence is not part of traditional Aboriginal or Torres Strait Islander cultures Violence against Aboriginal and Torres Strait Islander women and children is not a part of traditional culture. When violence occurred prior to colonisation, it was regulated and controlled, and bore no resemblance to the kinds of violence and abuse seen today. Many aspects of traditional culture and customary law were respectful and protective of women. As custodians of some of the longest surviving cultures in the world, Aboriginal and Torres Strait Islander people successfully managed interpersonal, family and community relationships for over 60,000 years prior to colonisation" (Our Watch, 2018).

"Violence against Aboriginal and Torres Strait Islander women is perpetrated by Indigenous and non-Indigenous men. Public debate and media reporting frequently imply that this violence is always perpetrated by Aboriginal or Torres Strait Islander men, when this is not the case. Violence against Aboriginal and Torres Strait Islander women is perpetrated by men from many cultural backgrounds. Anecdotal evidence suggests that non-Indigenous men make up a significant proportion of perpetrators. For intimate partner violence, this reflects data showing the majority of partnered Indigenous women have non-Indigenous partners, especially in capital cities. Perpetration patterns vary geographically, with this data suggesting violence against women in remote areas more likely to be perpetrated by Indigenous men, and violence in urban areas more likely to be perpetrated by non-Indigenous men" (Our Watch, 2018).

Many Aboriginal women who experience family violence have children in their care and exposure to the violence can have severe detrimental impacts to those children as with non-Aboriginal children. However, there are other salient contextual factors to consider. Race based policies that contributed to the Stolen Generation have contributed to ongoing cycles of intergenerational trauma for Aboriginal families. Involvement of child protection agencies in the lives of Aboriginal communities and families who experience family violence sometimes results in the removal of children and placed in out of home care. Family violence has been identified as one of the primary drivers for Aboriginal children entering out of home care and contributing to their overrepresentation in the child protection system. Fear of removal is a serious deterrent for Aboriginal and Torres Strait Islander women from help seeking behaviour (Our Watch, 2018).

Our Watch (2018) has developed a diagram outlining the key considerations in understanding Aboriginal family violence.



Family Violence

Family violence is a broader term that refers to violence between family members, as well as violence between intimate partners. Family violence occurs outside the context of Aboriginal family violence, but it is violence that occurs in the context of family systems. People who are part of family system are connected by virtue of birth, marriage or may co-reside. Family violence includes any pattern of behaviours that are coercive, controlling or causes family members to be fearful (WSSSA, 2019). Essentially it involves the same sorts of behaviours as described for domestic violence. As with domestic violence, the National Plan recognises that although only some aspects of family violence are criminal offences, any behaviour that causes the victim to live in fear is unacceptable.

Family violence is inclusive of violence between any family members so it can include violence by children and young people towards siblings and/or parents, mother and fathers violent towards children, and violence towards extended family members.

Risk

Risk sits firmly at the intersection of domestic violence and child protection. The most challenging aspect is the co-existence of risk to an adult victim and a child victim who are both linked but have separate needs. For WSSSA the primary focus of their risk assessment is to the adult victims of domestic violence and to ensure their safety and security. More recently however, WSSSA also includes children in the risk assessment process and safety planning process. For child protection, the primary focus of risk

assessment and intervention is the child. Although recognising that the non-offending parent, who are predominantly mothers, are also victims of domestic and family violence the focus of child protection is predominantly on their parenting capacity. In many circumstances, the focus of intervention predominantly involves the mothers and the fathers tend to retreat into the background (Stanley and Humphreys, 2014). Although, discussions have emerged in the co-design workshops, that child protection practitioners, where possible, involve fathers in risk assessments and safety planning although many challenges exist in their full involvement in this process.

Sharing understanding of risk, risk assessments and risk management will be a challenge for this collaborative service response. However, risk must be embraced as a defining theme when working in this complex context and that it must inform plans for safety for the mother and the child and keeping the perpetrator visible.

Comprehensive understanding of risk is required to inform management of those risks and development of intervention plans. Comprehensive assessment of factors that contribute to harm and danger is required but it is also necessary to simultaneously explore strengths and safety. Comprehensive risk assessment is informed by professional knowledge but equally informed by expertise and knowledge of the mothers and children, and other relevant key stakeholders (Turnell and Murphy, 2017).

The *National Risk Assessment Principles for domestic and family violence (ANROWS, 2018)* are inclusive of children outlines some principles that can inform our thinking in the development of shared understanding of risk assessment and risk management:

1. Survivors' safety is the core priority of all risk assessment
2. A perpetrators current and past actions and behaviours bear significant weight in determining risk
3. A survivor's knowledge of their own situation is central to any risk assessment
4. Heightened risk and diverse needs of cohorts are taken into account in risk assessment and safety management
5. Risk assessment and safety management strategies for Aboriginal and Torres Strait Islander peoples are community-led, culturally safe and acknowledge the significant impact of intergenerational trauma on communities and families
6. To ensure survivors' safety, an integrated, systemic response to risk assessment and management, whereby all relevant agencies work together, is critical.
7. Risk assessment and safety management work is part of a continuum of service delivery.
8. Intimate partner sexual violence must be specifically considered in all risk assessment processes
9. All risk assessment tools and frameworks are built from evidence-based risk factors.

Safety

Conducting comprehensive risk assessments informs risk management strategies and safety for women and children. Safety of children is the priority for child protection services and safety of women and their children is the key consideration for domestic violence specialist services. The challenge for this collaboration is to engage in shared decision-making processes and work towards the safety of women and children.

Safety involves the removal of risk factors and the enhancement of protective factors so that women and children can feel physically and emotionally safe. Achieving the safety of women and children also requires ensuring that the perpetrator is visible. Achieving safety requires immediate responses by child protection and WSSSA but also requires consideration of longer-term safety that attends to stability, security, healing and recovery. To achieve safety, domestic and family violence informed practitioners will assess the uniqueness of each family situation and respond according to their needs (WSSSA, 2019).

Elements of the Collaborative Service Response

The collaboration service response outlined in this paper is informed by the *Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services – the PATRICIA project* (Connolly, Healey & Humphreys, 2017) (See Appendix 1).

The collaboration begins with the Department for Child Protection and Women's Safety Services SA. The participants in the co-design sessions have grappled with the issue of keeping the perpetrator visible to ensure the safety of women and children. So, the collaborative service response begins with these two central agencies however based on the needs of the adults and children, collaboration may need to be extended to ensure the visibility of the perpetrator.

The focus of this collaboration is about meeting the safety needs of women and children and ensuring that the services working with the women and children are deliberating together in shared inclusive decision-making processes. These processes, as outlined in the practice approach, ensure that the right expertise is sitting together and responsive to the rights of children and their mothers so that there is equal investment in shared outcomes for women and children. This means that for Aboriginal and Torres Strait islander families there is Aboriginal and Torres Strait Islander representation.

The collaborative service response is dependent on a strong authorising environment working towards sustainability. The implementation of this collaborative service response has been endorsed by leadership staff in DCP, WSSSA and EIRD (DHS) and to whom this collaboration is accountable. The implementation of the collaborative service response reports to the Advisory Committee that has representation from all key organisations. This means that the collaboration is formalised allowing for deliberations about expectations, implementation of processes that support the collaboration, discussion about information sharing, assessments and case planning.

Theory of Change

The collaborative service response is informed by the belief that removal or risk of removal from family is present in the lives of children who experience risk due to domestic and family violence and other complex factors. The implementation of a collaborative service response between the Department for Child Protection and Women's Safety Services SA will improve outcomes for children and their mothers. The implementation of a collaborative service response will also result in increased knowledge and understanding of the pattern of perpetrator behaviours and how this impact on his parenting and safety of children and their mothers.

Collaborative Service Principles

Safety of children and their mothers

Culturally responsive practice

Shared language and understandings about domestic and family violence and child protection

Respectful relationships with families and among all professionals

Open to **critique and innovation**

Ethical **information sharing**

Commitment to open and ongoing conversations

Respectful of professionals and **their expertise**

Respectful of children and families and their expertise

Practice Foundations

The practice foundations may be altered as the project evolves and both organisations begin to develop shared understandings.

Child centred practice

Child centred practice is central to the work of DCP. The critical elements of child centred practice is that practitioners get to know the child, who they are, what they need and what is their understandings, views, opinions about their life circumstances and what they want for their future. It is recognising and ensuring that children participate in decision making processes and have a voice in decisions and processes that impact their lives. Being child centred is about seeing the world through their eyes, understanding their lived experiences particularly for children who live in contexts of complexity, and for practitioners to support their parents to reduce risk for the children to improve their safety and wellbeing (Barnes, 2018). It is important to note that practitioners who are child centred recognise that the safety and wellbeing of children is dependent on adults who are attuned to their needs and able to provide a safe and nurturing environment.

It is an approach adopted by WSSSA but can also be complex operating in this way particularly if the needs and wishes of the children are different to those of the mother. Children who are exposed to domestic and family violence not only suffer emotional harm but sometimes also experience physical and sexual harm and neglect. Tactics used by perpetrators can undermine the mother-child relationship compromising their sense of safety, security and relationship with their mother.

Child centred practice therefore requires practitioners to conduct comprehensive assessment considering their experiences and the impact of domestic and family violence including the assessment of the parent-child relationship. This assessment process is the foundational of role of DCP but can be informed by information held by WSSSA. The child's safety must be the paramount consideration however both agencies have the opportunity work together to nurture and/or restore the mother-child relationship and minimise further trauma for both.

Domestic and Family Violence Informed

Practitioners who are domestic and family violence informed understand and recognise the patterns of perpetrator behaviours and the impact of those behaviours on the safety and wellbeing of women and children. Family violence informed practitioners recognise the importance of:

- Validating and assessing the experiences of the victims of domestic and family violence and ensuring their immediate safety;
- Forming an alliance with the mother to ensure the safety of the child/ren;
- Maintaining a focus on perpetrator's behaviours and impact of those behaviours.

Practitioners who are domestic and family violence informed begin their risk assessment with understanding the pattern of the perpetrator's behaviour and how this impact on the children, their mothers and family functioning.

Children and families do not experience domestic and family violence in isolation from other risk factors. It is well known through recent research and practice wisdom that families who experience domestic violence can also experience mental health issues, substance abuse problems, homelessness, poor health outcomes and criminality (EIRD, 2018). However, family violence informed practitioners appreciate that individual's and families' experiences of these other issues can both shape and be shaped by their experiences of family violence. It is critical, therefore, for practitioners to explore the ways in which all family issues and challenges intersect with families' experiences of family violence in order to achieve family safety and wellbeing.

Culturally Responsive Practice

Culturally responsive practice begins with the recognition of intergenerational trauma that has resulted due to the cumulative impacts of colonisation, dispossession of land, loss of language and culture, the erosion of cultural and spiritual identity, and the forced removal of children, racism and discrimination (Our Watch, 2018). On this basis working with Aboriginal children and their families requires practitioners to respond differently.

In working with Aboriginal families and communities it is important to appreciate the centrality of culture for health and wellbeing. Kinship systems and connection to spiritual traditions, ancestry and country are important strengths to draw upon in Aboriginal communities. Fundamentally, it is important to take the time to engage with mother and their children and walk alongside to understand their suffering, their family and their culture. Aboriginal child rearing and commitment to family and community is a protective mechanism.

Culturally responsive practice can best be supported by understanding, respecting and drawing on Aboriginal expertise throughout the entire intervention process. Culturally responsive demands that when working with an Aboriginal family that Aboriginal practitioners within WSSSA and Principal Aboriginal Consultants within DCP are included in case discussions, assessments, case planning and reviews.

Trauma informed practice

Trauma-informed practice is built on an understanding of the pervasiveness of trauma and its impact for families. Trauma can be experienced individually and/or collectively. Individual trauma refers to an individual's experience of an event or events, and can impact an individual across physical, social, and emotional domains. Collective trauma refers to the impact of traumatic events on the functioning of a group, such as a family, or a community. Families may also experience historical, or intergenerational trauma, which refers to the cumulative historical and psychological damage that has occurred over a lifespan and across generations (Harris & Fallot, 2001). For Aboriginal families and communities, it is important to recognise that the trauma of colonisation is not just associated with events in the past, but frequently continues via oppressive understandings and practices that have become institutionalised.

Central to a trauma-informed perspective is an approach that shapes service responses from a vantage point of "what happened to you" rather than "what's wrong with you". Trauma-informed practitioners recognise that individual's and families' behaviours are most often survival strategies - and focus on family member's individual and collective strengths. Trauma-informed services are based on principles of respect, dignity, inclusiveness, trustworthiness, empowerment, choice, connection, and hope. Practice aims to attend to families' physical and emotional safety, to avoid retraumatising families, to support healing and recovery, and to facilitate meaningful participation of families in the design, implementation, and evaluation of services (Warshaw et al, 2012)

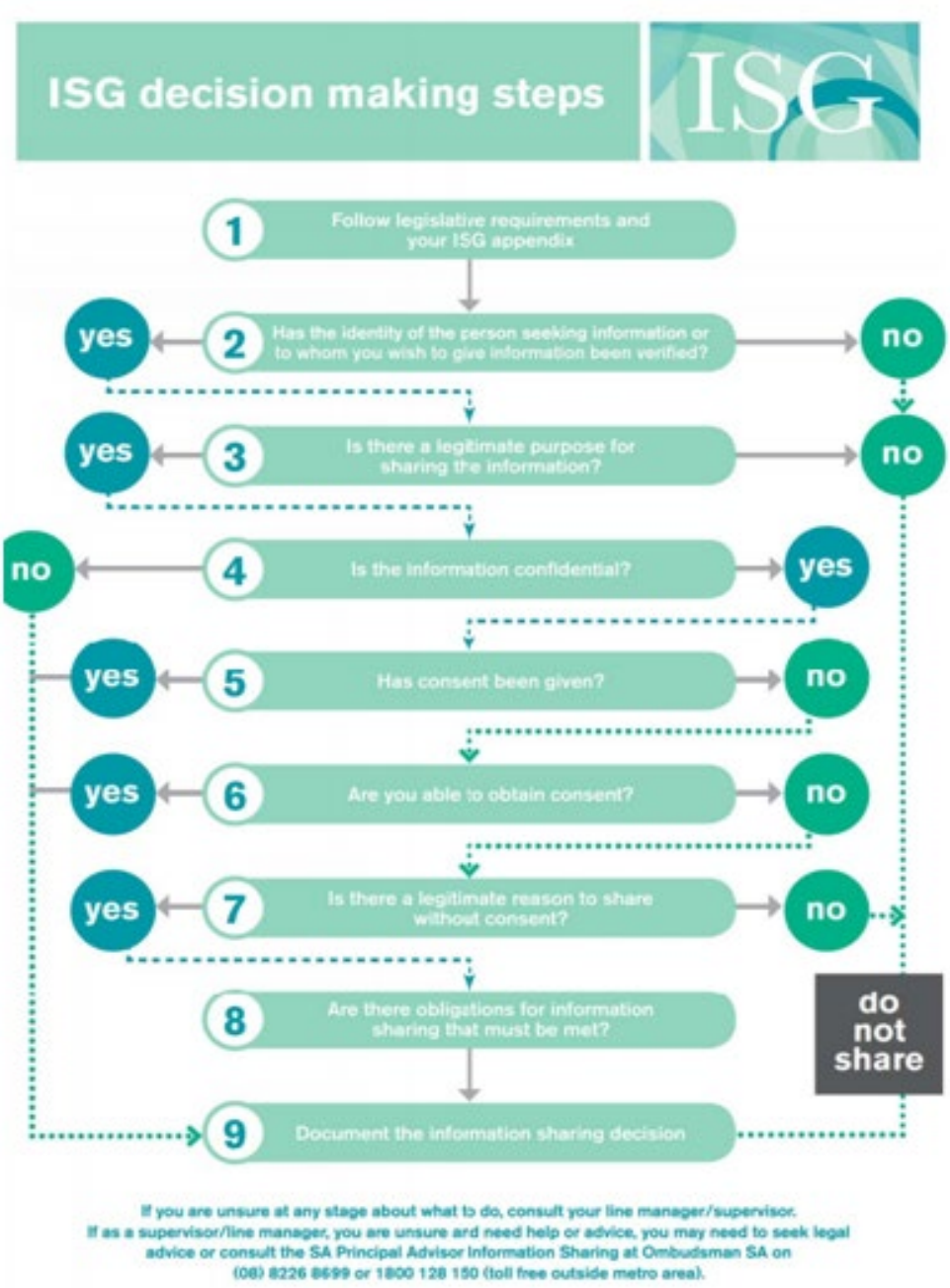
Information Sharing

The ability to share information across the Department for Child Protection and WSSSA has been identified as critical to successful collaboration and positive outcomes for children and their families. Information sharing and communication must occur in a manner that is timely, respectful and focused on ensuring the safety of children, their mothers and ensure that the fathers are visible.

The Department for Child Protection is currently reviewing its information sharing guidelines to ensure consistency with the Child and Young People (Safety) Act 2017 (CYPS Act). The CYPS Act provides the legal framework guiding the sharing of the information in relation to the protection and safety of children. Key sections of the legislation that support information sharing are as follows:

Key sections of the legislation	
Section 152	Information may be shared with prescribed bodies (generally government agencies, local government organisations and NGOs who are funded by Government) to assist these bodies to perform official functions or to protect children and young people from harm.
Section 163	This section protects the details of people who have notified that a child or young person may be at risk of harm. Notifier details must not be disclosed unless one of the exceptions set out in s163 applies. An example of an exception includes the consent of the notifier.
Section 164(1)(a)	The sharing of information is allowed or legally required under the CYPS Act or any other law
Section 164(1)(b)	Sharing information with the consent of the person to whom the information relates. The approach to seeking consent from a child or young person should be tailored to their age and developmental capacity.
Section 164(1)(c)	This allows information to be shared with any person where that disclosure is connected to the administration or enforcement of the CYPS Act or any other Act. This has a broad application and will generally cover circumstances where the sharing of information will assist in making arrangements for the protection and care of children and young people.
Section 164(1)(d)	Information may be shared where the disclosure is made to: • a law enforcement agency (such as South Australia Police), or • a person or agency exercising official duties under an Act relating to the care or protection of children and young people
Section 164(1)(e)	Information may be shared with an agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth for the purposes of the proper performance of its functions.
Section 164(1)(f)	Sharing information where it is reasonably necessary for the protection of the lawful interests of the person disclosing the information. *This exception will only apply in rare circumstances and legal advice should be sought on a case by case basis before relying on this exception.*

These provisions must be enacted in conjunction with the ISG. These guidelines are used within the context of Family Safety Framework and therefore relevant for the collaboration between DCP and WSSSA.



Family Liaison Specialist

As part of this collaborative service response, the Department for Child Protection has funded the establishment of a specialist Family Liaison Specialist in the Southern Women's Safety Services SA. The Family Liaison Specialist (FLS) will form the bridge between DCP and WSSSA and will be based in the Southern Adelaide Domestic Violence Service.

The Family Liaison Specialist is a new position, where the incumbent will provide case management services to children and families and be involved in the implementation of a collaborative service response between Women's Safety Services SA and Department for Child Protection. The Family Liaison Specialist will also work closely with staff from the Social Work Innovation Research Living

Space (SWIRLS) (Flinders University) funded by Early Intervention Research Directorate (DHS) in the development and evaluation of the service response. Case management and services to be provided to families within the Southern Adelaide Domestic Violence (SADVS) and Ninko Kurtangga Patpangga (NKP) with the aim to increasing safety and wellbeing of children who are also involved with DCP and WSSSA services. The Family Liaison Specialist will:

- work in cross cultural settings to respond to the needs and circumstances of First Nation women and children, CALD and Anglo women and children that supports children to stay or be reunited with their family of origin.
- Undertake the provision of trauma informed specialist intervention, casework and group work programs to facilitate holistic responses to children and families in a variety of settings.
- Participate in the development and implementation of the collaborative service response to enhance the safety of women and children, strengthen parent/child relationships and build resilience and capacity to deal with the effects and impact of violence.
- Participate in the implementation of the collaborative service response across DFV sector and Department for Child Protection by engaging in research and evaluation activities
- Be involved in the implementation and evaluation of service responses.
- Build relationships and work closely with staff from DCP to ensure the safety and protection of children who have experienced domestic and family violence and
- Contribute to the identification of "best practice" in the context of domestic and family violence
- Promote and provide educative-based programs within the region that enhance service responses to children and young people.
- Participate in across agency professional development activities as required.

The FLS is a new role and the implementation of this role will be evaluated and will evolve within the context of the collaborative service response.

Collaborative Service Description

Aims

The aims of this collaborative service response it to achieve the following:

- Children's safety is a primary consideration
- Mothers are afforded opportunities and support to ensure their safety and the safety of their children
- Reduce service system chaos
- Promote healing and recovery of children and their mothers
- Reduce renotification to child protection system
- Identify and name the behaviours of the perpetrator and recognise the impact on children and their mothers.
- Increase visibility of the perpetrators to keep women and their children safe

Target Population

The beginning point of this collaborative service is triggered by children and families who are in receipt of services from both the Department for Child Protection and Women's Safety Services SA. There is also capacity for collaboration to be triggered through the following processes:

- Consultation with FLS either by WSSSA or DCP to facilitate increased communication or access to services,
- FLS to attend meeting with woman experiencing domestic and family and involved with DCP. the FLS will only attend meeting if woman has given consent and it is safe to do so. The joint visit will provide an opportunity to discuss safety planning, provide information about resources about domestic and family violence, facilitate assessment through Domestic Violence Crisis Line to improve safety outcomes for women and children

Consent

Each agency should seek written consent from families to share information where possible. This is considered a normative practice across agencies to ensure families are aware of communication and information sharing that occurs across service systems. In the context of seeking consent, it is also advisable to let clients know that WSSSA and DCP are working closely together to improve outcomes for women and their children and they will be contacted to offer them the opportunity to be involved in the collaborative service development. If the families decide they do not wish to be contacted or participate in the collaborative service development this does not impact on them receiving a service.

Child Protection

DCP has received a notification and an assessment has been made that the children have been harmed or at risk of harm due to the presence of risk factors including domestic and family violence. The child's circumstances warrant statutory intervention and the "screened in" notification is forwarded to the relevant DCP office. The case is opened, an investigation conducted, intervention initiated, and case manager/caseworker allocated. The focus of child protection statutory intervention is to ensure the safety of the child through change of the family circumstances. Change in circumstances must ensure the safety of the child through reduction of risk factors (e.g. no longer living in a context of violence; safety planning to reduce violence; change in living arrangements) and increase in protective factors (e.g. active engagement with services, mother and child seeking support, perpetrator visible and accountable; engagement of extended family members). If the child and the mother continue to experience violence and the perpetrator is unwilling to engage in behaviour change management and safety planning, the child/ren may be at risk of removal. In extremely high-risk situations and where neither carer is able or willing to provide a safe environment, children may be removed from their biological parents and placed in out of home care which may include kinship care. Mothers may be unable to care for their children due to the severe impact of trauma. For some of these children, plans for reunification or establishing best connection have been actioned. In these situations, DCP staff

provide case management services to ensure the long-term safety and wellbeing of the child. In some situations, the women have sought or are receiving services from WSSSA.

Women's Safety Services SA

Women and their child/ren may enter the WSSSA service system via different pathways including self-referral, referral from another part of the agency (e.g. 1800RESPECT), referral by another agency, referral through an informal support such as friend or family or assertive engagement where WSSSA are requested to make contact (e.g. Family Safety Framework). On entry to the service WSSSA staff will ensure the mother and child are safe through provision of accommodation, conduct a risk assessment, engage in DFV counselling, provide case management services based on need of the woman and her child/ren. Case management services are responsive to the needs of the mother and child/ren to re-establish their lives that is free of violence. Some of these women are also involved with the Department for Child Protection and they are required to engage actions to ensure that their children are either safe or can return to their care.

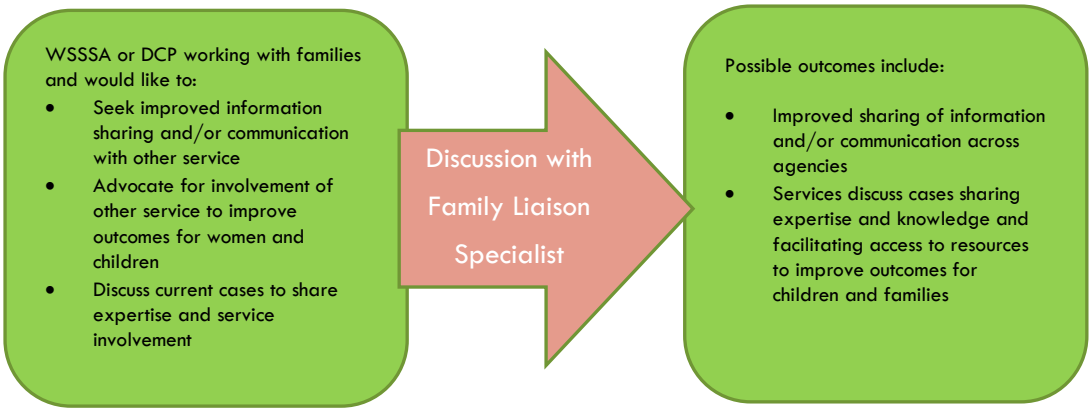
Services for Perpetrator

What is missing from this target population is the visibility and accountability of the perpetrator which needs to be explored and developed.

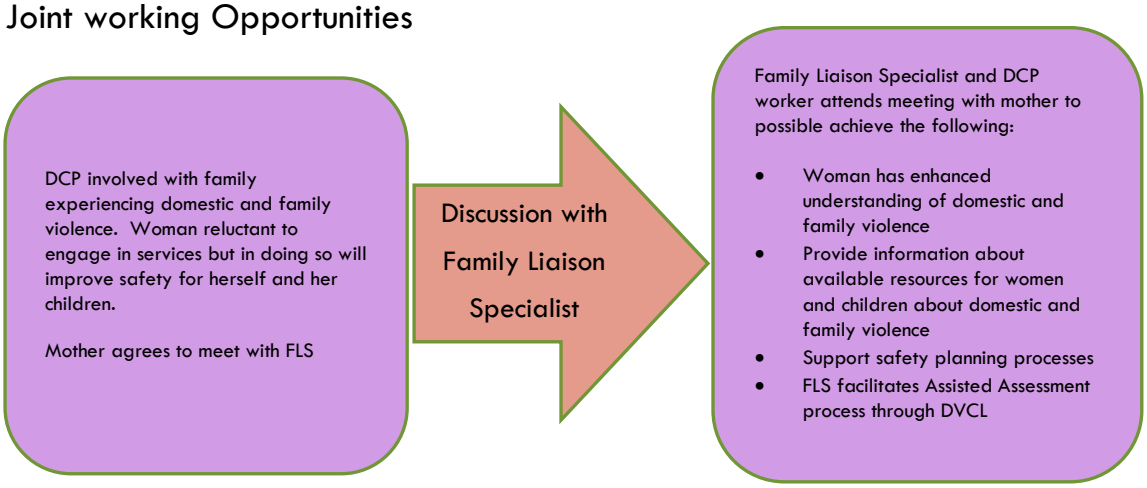
Practice Approach

Collaboration is not limited to families and children where both agencies are involved. Short term collaboration may be initiated through processes of consultation and joint working. The FLS is a valuable resource that works across WSSSA and DCP and can enable access to services or enhance communication when required.

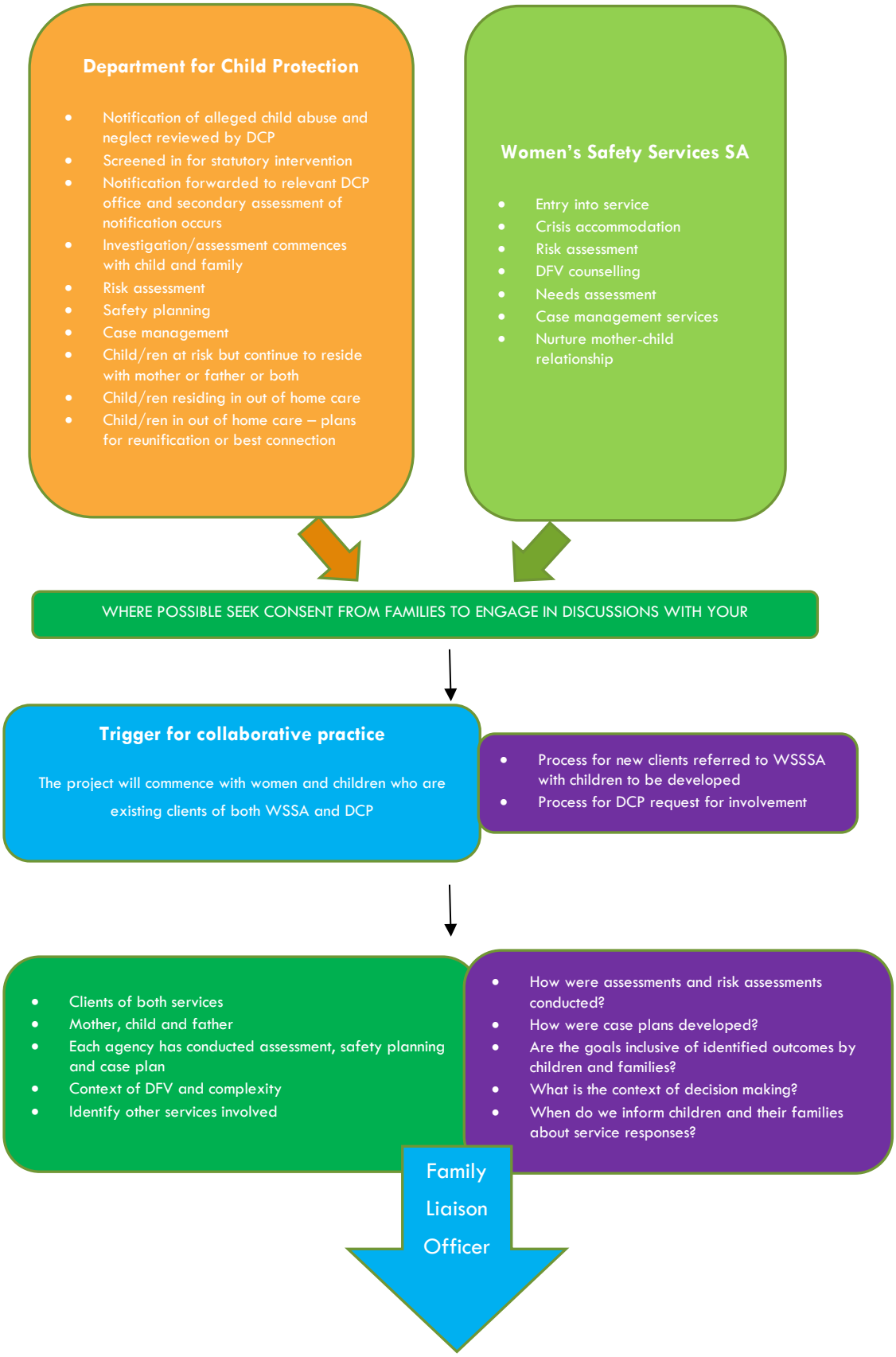
Consultation with Family Liaison Specialist

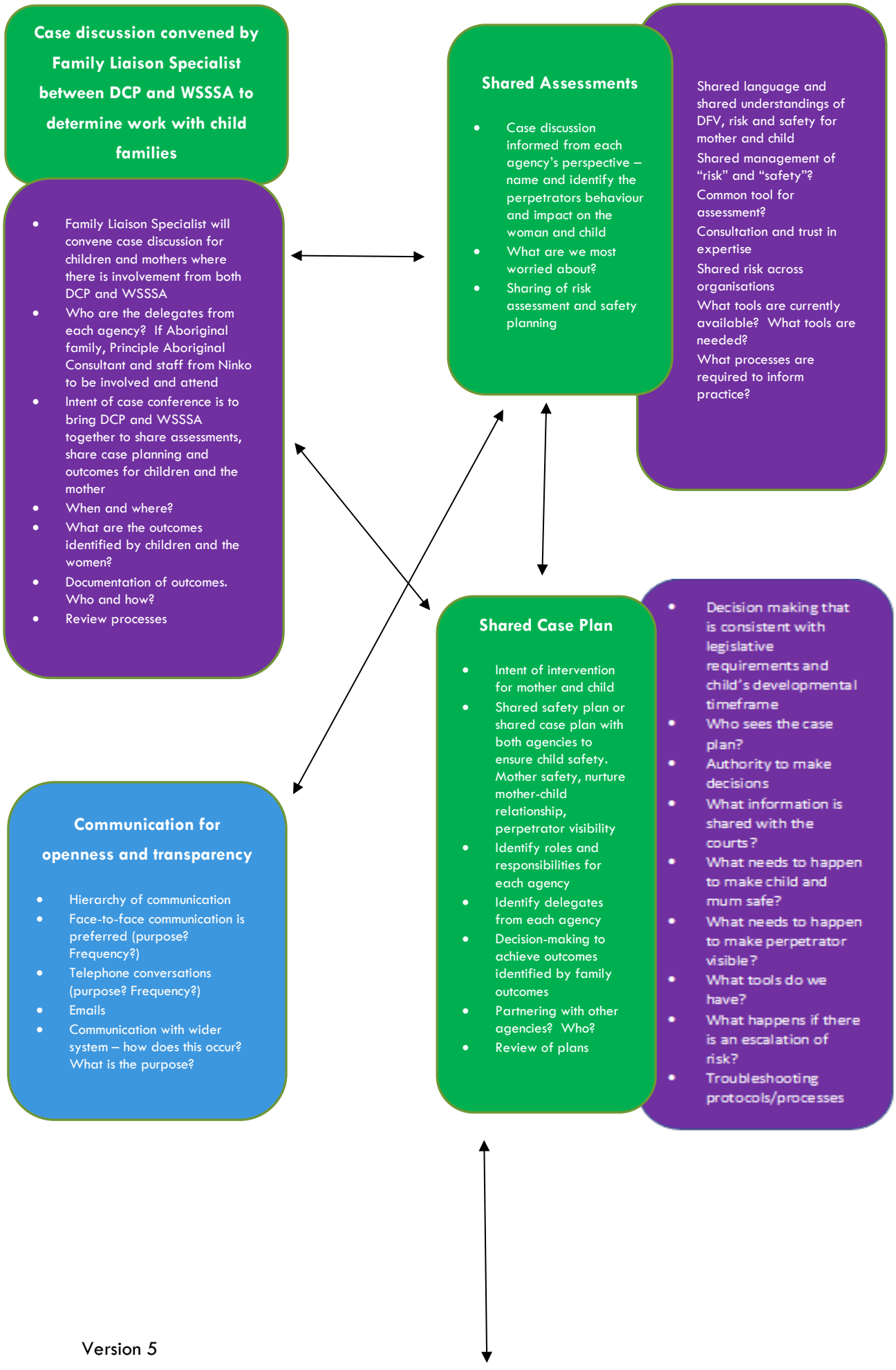


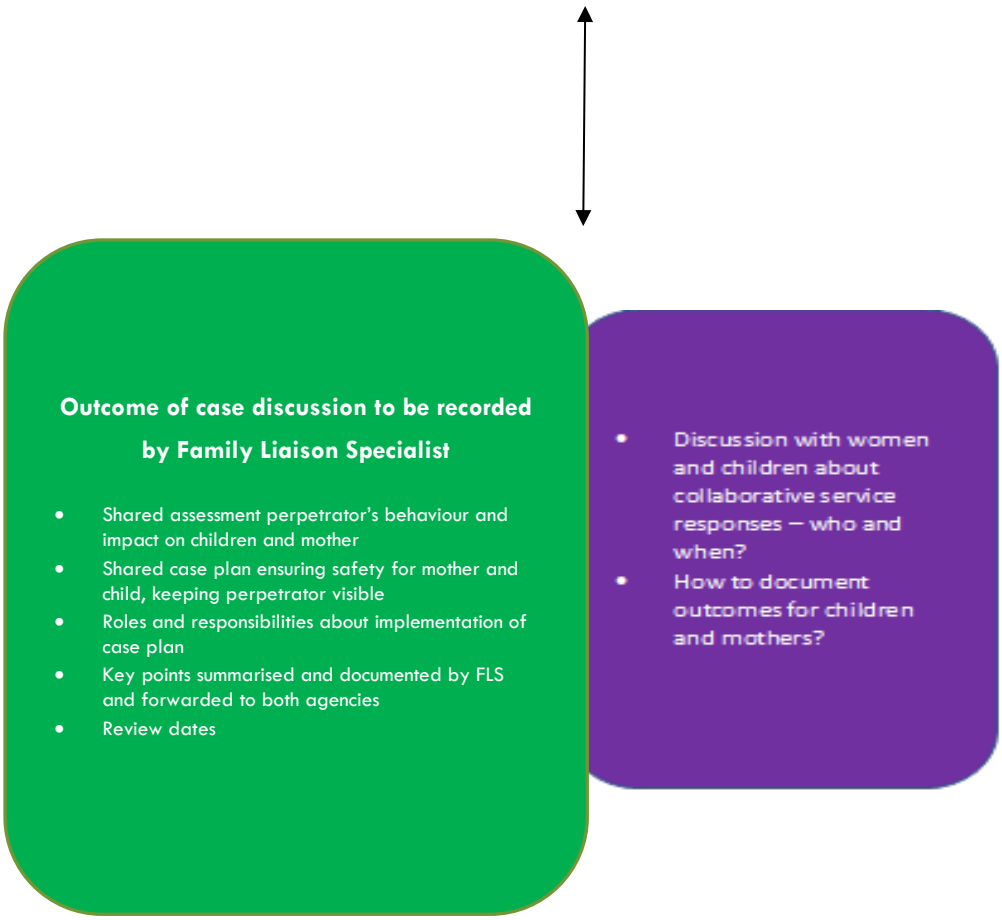
Joint working Opportunities



Collaborative Service Response – Families receiving services from DCP and WSSSA




Case discussion convened by Family Liaison Specialist between DCP and WSSSA to determine work with child families
Family Liaison Specialist will convene case discussion for children and mothers where there is involvement from both DCP and WSSSA
Who are the delegates from each agency? If Aboriginal family, Principle Aboriginal Consultant and staff from Ninko to be involved and attend
Intent of case conference is to bring DCP and WSSSA together to share assessments, share case planning and outcomes for children and the mother
When and where?
What are the outcomes identified by children and the women?
Documentation of outcomes. Who and how?
Review processes
Shared Assessments
Case discussion informed from each agency's perspective – name and identify the perpetrators behaviour and impact on the woman and child
What are we most worried about?
Sharing of risk assessment and safety planning
Shared language and shared understandings of DFV, risk and safety for mother and child
Shared management of "risk" and "safety"?
Common tool for assessment?
Consultation and trust in expertise
Shared risk across organisations
What tools are currently available? What tools are needed?
What processes are required to inform practice?
Shared Case Plan
Intent of intervention for mother and child
Shared safety plan or shared case plan with both agencies to ensure child safety. Mother safety, nurture mother-child relationship, perpetrator visibility
Identify roles and responsibilities for each agency
Identify delegates from each agency
Decision-making to achieve outcomes identified by family outcomes
Partnering with other agencies? Who?
Review of plans
Decision making that is consistent with legislative requirements and child's developmental timeframe
Who sees the case plan?
Authority to make decisions
What information is shared with the courts?
What needs to happen to make child and mum safe?
What needs to happen to make perpetrator visible?
What tools do we have?
What happens if there is an escalation of risk?
Troubleshooting protocols/processes
Communication for openness and transparency
Hierarchy of communication
Face-to-face communication is preferred (purpose? Frequency?)
Telephone conversations (purpose? Frequency?)
Emails
Communication with wider system – how does this occur? What is the purpose?


Outcome of case discussion to be recorded by Family Liaison Specialist
Shared assessment perpetrator's behaviour and impact on children and mother
Shared case plan ensuring safety for mother and child, keeping perpetrator visible
Roles and responsibilities about implementation of case plan
Key points summarised and documented by FLS and forwarded to both agencies
Review dates
Discussion with women and children about collaborative service responses – who and when?
How to document outcomes for children and mothers?

Appendix 1

Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services

	Building partnership	Supporting safe decision-making for woman and children	Sustaining collaboration
Integrated service focus	• Do we have the primary services involved in the collaboration: CP and specialist DFV? • Are cross-agency service protocols in place, including meaningful involvement with family law? • Are we exploring responsive service pathways for women and children? • Are there linkages with specialist services—e.g. MH, DOA, disability, Indigenous, CALD?	• Do we have a common language around risk and perpetrator accountability? • Do decisions support the mother–child relationship? • Do we have all the appropriate information we need to make safe and good decisions? • To what extent is information sharing based on victim-centred practice?	• To what extent do workers trust services will respond appropriately to referred clients? • Do we need new collaborative practice tools? • In what ways are we sharing data and data analysis to inform service improvement? • Are key members remaining in the collaboration?
Democratising practice	• Does the partnership have a shared commitment to and understanding of women's and children's safety and perpetrator accountability? • Do we have a shared and equal investment in outcomes for women and children? • Does the partnership embrace diversity with meaningful representation—e.g. Indigenous, CALD, disability, LGBTIQ?	• Is decision-making collaborative? • Are decisions focused on perpetrator accountability? • Who exercises decision-making authority in the partnership? • Does the collaboration support alternative pathways for referrals relating to children?	• Do we have equal voices in the partnership? • Are we monitoring progress against the collaborative vision? • In what ways do our systems promote safe information sharing, and is this working to support the safety of women and children?
Partnership supportive collaboration	• Do we have champions supporting the collaboration? • Is there space for relationship-building? • Is the collaboration formalised within a supportive authorised environment? • Are the expectations of collaboration clearly authorised—e.g. in PDs?	• Are we working towards responsive risk assessment–informed triaging? • Are women and children safer through the collaboration, and how do we know? • Are we evaluating the collaboration and identifying and engaging new DFV-sensitive champions?	• In what ways is the collaboration fostering stability and managing change? • Is the collaboration open to new ideas and challenges? • What opportunities are there for relationship-building and joint training?

Connolly, M; Healey, L and Humphreys, C. (2017) The Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: Key findings and future directions. ANROWS: NSW.

Appendix 2: Implementation plan for Prototype

TASK	DETAILS	RESPONSIBILITY	DATE COMPLETED
Starting date	• Starting date will be the **4th November.** • This will give the Family Liaison Specialist time to orientate to their new position • Become familiar with the operations of Women's Safety Services SA • Become familiar with the Department for Child Protection and establish key relationships • Orientate themselves to the collaborative service responses and work with researchers in relation to research project • Develop any documents or processes to facilitate the service response and data collection • Organise information sessions for DCP and WSSSA staff	Carmela to co-ordinate meeting with FLS and supervisor to discuss how best to commence	
Starting Point	• The target group for this collaborative service response are families who are existing recipients of the Department for Child Protection and Women's Safety Services SA. • FLS practitioner to identify currently active cases that are managed by WSSSA and DCP • Commence collating names of delegates from each organisation to facilitate case discussions		

	We have some definitions in the document as a starting point however these need to be further developed based on work currently in progress across both organisations	Carmela	
	Case discussions to be scheduled when FLS practitioner familiar with cases. Case discussions will involve Family Liaison Specialist, WSSSA case manager, DCP case manager. Principal Aboriginal Consultant and/or practitioner from Ninko to be present for Aboriginal families; Principal Social Workers to be invited. Due to ethical restrictions, researchers not able to attend case discussions.	Family Liaison Specialist	
	What about visibility of perpetrator?	Megan and Carmela to discuss involvement of SAPOL from Multi-agency Hub in WSSSA	
	An information sheet will be developed and an email will be generated to be forwarded to Managers of each relevant office to inform staff DCP and WSSSA, so they are aware of the commencement of the collaboration.	Carmela	
	Information sessions to be established with DCP staff in Noarlunga and St Mary's	Carmela and FLS	
	Information session to be set up with staff at Ninko and SADVS with FLS	Carmela and FLS	

Managing any problems that emerge	Troubleshooting processes to be developed through the process of implementing the prototype If the Family Liaison Specialist identifies that decision making is not shared or there is a "stuckness" with families then she discusses with her direct supervisor. Plan to be devised and documented as the issue, deliberation about the issues and how the issue was resolved.	FLS and Tiffany/Megan Carmela	
Data collection	• Overview of case discussions will be recorded by FLS and filed in case files for women and children • Form to be developed by researcher and FLS • Reflective discussions for 15 minutes with participants of case discussions following completion of each case discussion – discussions audiotaped but not transcribed. Audiotape will be used to inform note taking • Family Liaison Specialist to document case progress and case discussions (how this will occur to be determined) • Document and understand what seem to be working, how does it work, for the children and mothers in this context. • Children and families to be interviewed and consent sought to read their case files. How do we involve fathers? • Reflective discussions with practitioners who attend co-design sessions in February and June.	FLS Researcher to attend To be discussed further.	

	• Data collection evaluating the position of Family Liaison Specialist		
Review of Prototype	Review meeting to be set up – one in early February and one in June Determine what seems to be working and what doesn't against mapping of outcomes for children and families	Carmela, Sarah and Jenny and FLS	
Sustainability	To be discussed as the collaborative service response progresses.		

References

Australian Institute of Health and Welfare 2018. *Family, domestic and sexual violence in Australia 2018*. Cat. no. DFV 2. Canberra: AIHW.

Australian Institute of Health and Welfare 2019. *Child protection Australia: 2017–18*. Child welfare series no. 70. Cat. no. CWS 65. Canberra: AIHW.

Blagg, H., Bluett-Boyd, N., & Williams, E. (2015). Innovative models in addressing violence against Indigenous women: state of knowledge paper.

Blythe, B., Heffernan, K., & Walters, B. (2010). Best practices for developing child protection workers' skills: Domestic violence, substance abuse, and mental health training. *Revista de Asistenta Sociala*, (2), 51.

Coll, K. M., Stewart, R. A., Morse, R., & Moe, A. (2010). The value of coordinated services with court-referred clients and their families: an outcome study. *Child welfare*, *89*(1).

Connolly, M; Healey, L and Humphreys, C. (2017) The Collaborative Practice Framework for Child Protection and Specialist Domestic and Family Violence Services: Key findings and future directions. ANROWS: NSW.

Council of Australian Governments. (2011). *National Plan to Reduce Violence Against Women and their Children 2010-2022*. Canberra: Commonwealth of Australia.

Cripps, K., & McGlade, H. (2008). Indigenous family violence and sexual abuse: Considering pathways forward. *Journal of Family Studies*, *14*(2-3), 240-253.

Harris M., Fallot R.D., eds. (2001). *Using trauma theory to design service systems*. San Francisco: Jossey-Bass.

Early, T. J., & GlenMaye, L. F. (2000). Valuing families: Social work practice with families from a strengths perspective. *Social work*, *45*(2), 118-130.

Healey, L., Connolly, M., & Humphreys, C. (2018). A collaborative practice framework for child protection and specialist domestic and family violence services: Bridging the research and practice divide. *Australian social work*, *71*(2), 228-237.

Humphreys, C., & Healey, L. (2017). *Pathways and Research Into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report* (ANROWS Horizons 03/2017). Sydney: ANROWS.

Laing, L. (2003). *Domestic violence in the context of child abuse and neglect*: Citeseer.

McDonald, M., & Rosier, K. (2011). Interagency collaboration. *Australian Family Relationships Clearinghouse AFRC Briefing*, 1-10.

Nyland, M. (2016). *The life they deserve: Child protection systems Royal Commission Report*. Government of South Australia.

Olsen, A., & Lovett, R. (2016). *Existing knowledge, practice and responses to violence against women in Australian Indigenous communities: State of knowledge paper*. ANROWS.

Our Watch, ANROWS and VicHealth (2015) *Change the Story*: A shared framework for the primary prevention of violence against women and their children in Australia. Our Watch, Melb., Australia.

Our Watch, ANROWS and VicHealth (2018) *Changing the Picture:* A national resource to support the prevention of violence against Aboriginal and Torres Strait Islander women and their children. Our Watch, Melb., Australia. Patton, M. Q. (1994). Developmental evaluation. *Evaluation Practice*, 15, 311–319.

Robinson, A. L. (2004). *Domestic violence MARACs (multi-agency risk assessment conferences) for very high-risk victims in Cardiff, Wales: A process and outcome evaluation*. Cardiff: Cardiff University.

Ross, S., Healey, L., & Humphreys, C. (2015). Integrated governance of family violence: Role and regional variations in expectations and experiences. *Journal of Human Services Administration*, *75*, 125–259. doi:10.1111/1467-8500.12162

Child Protection South Australia (2019) *Aboriginal Action Plan 2019-2020*. South Australia: Department Child Protection. Retrieved from: https://www.childprotection.sa.gov.au/__data/assets/pdf_file/0015/107034/aboriginal-action-plan-2019-2020.pdf

Scott, D. (2005), Inter-organisational collaboration in family-centred practice: A framework for analysis and action. *Australian Social Work*, 58: 132-141. doi:10.1111/j.1447-0748.2005.00198.x

Stanley, N., & Humphreys, C. (2017). Identifying the key components of a'whole family' intervention for families experiencing domestic violence and abuse. *Journal of gender-based violence*, *1*(1), 99-115.

Tarzia, L., Humphreys, C., & Hegarty, K. (2017). Translating research about domestic and family violence into practice in Australia: possibilities and prospects. *Evidence & Policy: A Journal of Research*, Debate and Practice, 13(4), 709-722. doi:10.1332/174426416X14742825885830

Tomison, A.M. (2000), Exploring Family Violence: Links between child maltreatment and domestic violence. NCPC Issues No. 13. Melbourne: Australian Institute of Family Studies

Trute, B., & Hiebert-Murphy, D. (Eds.). (2013). *Partnering with parents: Family-centred practice in children's services*. University of Toronto Press.

Warshaw C., Sullivan C. and Rivera E. (2012). A systematic review of trauma-focused interventions for domestic violence survivors. NCDVTMH.

Wendt, S. and Zannettino, L. (2015), *Domestic Violence in Diverse Contexts: A Re-Examination of Gender,* Routledge.

Wendt, Jones and Bastian, 2018

Wilkie, M. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Human Rights and Equal Opportunity Commission.

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

Document Control

This is a living document. This means that the content of this document and particulars of this collaborative service response will evolve over the course of the research project. All changes will be informed by research findings, the practice wisdom and experiences of the practitioners and the voices of the children and families who will be recipients of the service.

Publication date	Version 1 published and distributed 15th October, 2019
Replaces	
Document owner	SWIRLS, WSSSA and DCP Managed and edited by Dr Carmela Bastian
Applies to	*Collaborative Service Response – DCP and WSSSA*
Approved by	Participants at Co-design meeting Advisory Group Working group party
Approval date	15th October, 2019
Commencement date	4th November, 2019

REVISION RECORD		
Date	**Version**	**Revision description**
04/011/2019	2	Revisions made following co-design meeting held on 15th October, 2019
05/11/2019	3	Revisions made following feedback from Sarah Wendt and meeting with WSSSA staff on 4/11/2019
4/02/2020	4	Changes made to prototype diagram to align with summary sheet for practitioners
4/11/2020	5	Changes made to prototype following working group meetings and co-design workshop to review prototype

Appendix 4

Flinders UNIVERSITY

Social Work
Innovation Research
Living Space

SWIRLS

Social Work Innovation Research Living Space

The Hidden Families: Collaboration between women's shelters and child protection.

Dr Carmela Bastian

Professor Sarah Wendt

Ms Tessa Cunningham

Dr Amy Bromley

August 2023

CONTENTS

List of Figures and Tables

Acknowledgements

The report must begin with an acknowledgement of the children and young people who were at the centre of this study. This report highlights the complexities experienced by children and families who live in a context of domestic and family violence and child protection and the associated challenges to keeping them safe.

We thank the Early Intervention Research Directorate (EIRD) within the Department of Human Services, Government of South Australia, for funding and supporting this research.

We also thank the staff from the Department for Child Protection (DCP), and Women's Safety Services SA (WSSSA) (Megan Hughes and Desarae Chandler) for their commitment in telling these stories, allowing access to the case files, and their practice knowledge.

Government of South Australia
Department of Human Services

Government of South Australia
Department for Child Protection

This document has been produced by Social Work Innovation Living Space (SWIRLS) (March 2021) by Dr Carmela Bastian and Professor Sarah Wendt

Children living in women's shelters are not always safe. The ongoing impacts of trauma may continue to affect the whole family.

Executive Summary

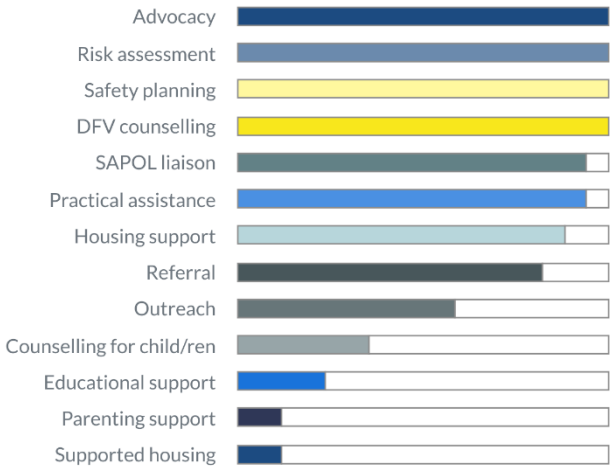
Women's shelters are increasingly providing services for children with highly complex needs.

Women's shelters are expected to manage high levels of risk for children.

Collaboration is impeded by differing understandings and assessment of risk and the differing mandates and thresholds for intervention across the sectors.

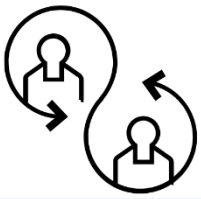
Shelter workers often feel a clash of values between feminist principles and the realities of complexity when child protection concerns are present.

Service Provision



Summary Findings

Children are entering shelters with complex abuse and neglect as a result of domestic and family violence, and women experience complex issues due to their own long-term trauma, which in many circumstances diminishes their parenting capacity.



Recommendations

- Implement a child-centred practice approach within women's shelters and employ additional specialist to enable the realisation of this work.
- Resource and build capacity in existing structures and expertise within women's shelters, which can enable specialist practitioners to respond to the needs of children and their mothers.
- Establish formalised collaborative links, such as a designated contact person in DCP, who can respond to women's shelter concerns of cumulative harm, rather than treating concerns as new and incidence-based concerns recorded through CARL.

Women

- Mental health issues
- Homelessness
- Financial issues
- Parental stress
- Substance use issues
- Criminal behaviour
- Childhood trauma
- Physical disability

Men

- Mental health issues
- Homelessness
- Financial issues
- Parental stress
- Substance use
- Criminal activity
- Childhood trauma
- Other

Children

- Sexual abuse
- Emotional neglect
- Physical neglect
- Supervisory neglect
- Physical abuse
- Emotional abuse

Children need more support within women's shelters.

The high volume of cases impacted collaboration.

DFV risk scores often remained 'high risk' within the shelter.

"How you manage risk, and different views about what that looks like across organisations, is a really interesting thing to unpack, and to look at."

Introduction

The impacts of domestic and family violence on women's and children's lives are well established, and the importance of intersectional understandings of women's and children's lives across ethnicity, class, race, disability, sexuality, and rurality, as well as intersectional issues such as drug and alcohol addiction and mental health, are widely acknowledged. The complexities of families' lives come to the forefront when intersectional issues co-exist with domestic and family violence (Humphreys, et al, 2020). Responding to the children and families who live in a context of complexity pose significant challenges for the service sector. Research has discussed that collaboration between domestic and family violence services and child protection systems are fraught and often absent because of different understandings that contribute to such complexity in the lives of women and children, which is also compounded by organisational mandates (Wendt et al, 2021). Practice at the intersection of statutory child protection and specialist domestic and family violence are predominantly driven by crisis responses, hence collaboration for longer term trauma services for women and children are harder to establish.

The difficulty of managing complexity is a recurring theme within these fields as the challenges include risk management, uncertainty, and volatility, particularly when families want to remain together. This complexity is further exacerbated by the presence of drug and alcohol misuse and mental health issues. Without understanding how domestic and family violence shapes or influences such intersectional matters, mothers and fathers can be positioned as passive in their parenting and therefore child removal becomes the only option. A recent study conducted by Wendt et al (2021) demonstrated that there is an appetite nationally and locally for developing and adopting better collaborative and integrated service structures and practices that recognise and respond to child protection and domestic and family violence concerns.

Several states in Australia have developed domestic and family violence policies and practice guidelines for child protection staff, which is helpful; however, there needs to be a greater focus on developing capacity for gender-sensitive, trauma-informed child safety responses if early intervention goals are to be achieved (Wendt et al, 2021). Furthermore, to provide the gender-sensitive and trauma-informed responses, child protection staff need to be able to create sustained connections with domestic and family violence and Aboriginal specialist service systems. These collaborations have the potential for joint risk assessment, relationship building with families, gathering perpetrator information, and engaging with perpetrators safely (Humphreys & Healey, 2017). Developing a stronger connection

between child protection and domestic and family violence specialist services has not always been a priority because of historical tensions and organisational silos. Yet with clear governance, managerial commitment, and establishment of a learning culture that is operationalised via specific and shared practical structures, resources and tools, collaboration can make a difference in the lives of South Australian women, children, and men.

The Focus of this Report

This research report is part of the larger research agenda *"Building collaboration at the intersection of domestic and family violence and child protection"*. The overarching research agenda focused on the safety needs of women and children through the collaboration of statutory child protection services and specialist domestic and family violence services. A co-designed prototype to build collaboration was established by the Department for Child Protection (DCP) and Women's Safety Services SA (WSSSA) to ensure that the right expertise was sitting together and responsive to the rights of children and their mothers. This enhanced their equal investment in the shared outcomes for women and children. For Aboriginal and Torres Strait islander families there was Aboriginal and Torres Strait Islander representation. The prototype was informed by the belief that removal or risk of removal from family is present in the lives of children who experience domestic and family violence and other complex factors. The implementation of a prototype to build a collaborative service response between the Department for Child Protection (DCP) and Women's Safety Services SA (WSSSA) was established to improve outcomes for children and their mothers through increased knowledge and understanding of the pattern of perpetrator behaviours and how these impacts on his parenting and the safety of children and their mothers. The outcomes of the prototype are discussed and outline in a separate report submitted to EIRD.

During the implementation phase (February 2021) of the prototype there emerged some challenges in the number of referrals and the level of collaboration between WSSSA and DCP which was not consistent with the ethos of the prototype. During discussions with the working group, it emerged that WSSSA was working with a cohort of families they called the "hidden families". The hidden families were identified as women and children who were residing in WSSSA accommodation seeking safety and refuge from domestic and family violence but there continued to be child protection issues. Children and young people were safe from domestic and family violence from which they sought refuge, but they continued to experience abuse and/or neglect from their mothers who were engaging in unsafe

parenting practices consequential to the profound experience of trauma. In these circumstances and for the hidden families, WSSSA articulated that they often sought support, advice, and intervention from DCP however for many of the families DCP was unable to provide such requests. According to DCP policies and practices, children were considered "conditionally safe" – that is, *"Safety threats have been identified and temporary, robust interventions have been put in place to mitigate or manage each safety threat*" whilst residing in WSSSA accommodation. These service dynamics and challenges were not evident when the prototype was co-designed. Women's shelters such as WSSSA are traditionally established to care for the needs of women seeking refuge from violence. The women's shelters are increasingly providing services to children who have high and complex needs while not resourced, equipped, or mandated to respond child protection issues. In this scenario, there is a service sector expectation that the specialist domestic and family violence will manage the risk associated with child protection issues experienced by the children without necessary supports which contravened the ethos of the collaboration.

The working group requested that this "invisible" work managed by the WSSSA's be explored and made visible. The project was pivoted to understand the hidden families. In doing so, it was argued, that this would provide an evidence informed opportunity to redefine collaborative responses required for the families and their children at the intersection of domestic and family violence and child protection. On this basis an analysis was conducted on a cohort identified as "hidden families", that is, women and children residing in women's shelters where children continued to experience significant child protection concerns.

Method

Research Design

This research study was informed by a qualitative research design to collect information from case files and a focus group with specialist domestic and family violence practitioners servicing southern Adelaide. This approach enabled the researchers to develop an understanding of the concept of the "hidden families" used by the domestic and family violence practitioners. The term highlighted they did work with children with child protection concerns, but not in close collaboration with the statutory organisation (DCP) as first assumed within the larger research agenda. A partnership between the research team (authors) and the specialist domestic and family violence service (Women's Safety

Services SA, southern site) facilitated access to the case files. Practice research that is conducted in partnership generates trust, research excellence, practice wisdom, and expert knowledge from practitioners that mirrored the key elements of collaboration from the broader research agenda (Tiesinga & Berkhourt 2014).

Research questions

To again an understanding of the work with children in the context of domestic and family violence when there were child protection concerns inside a women's shelter, the following research questions guided the study:

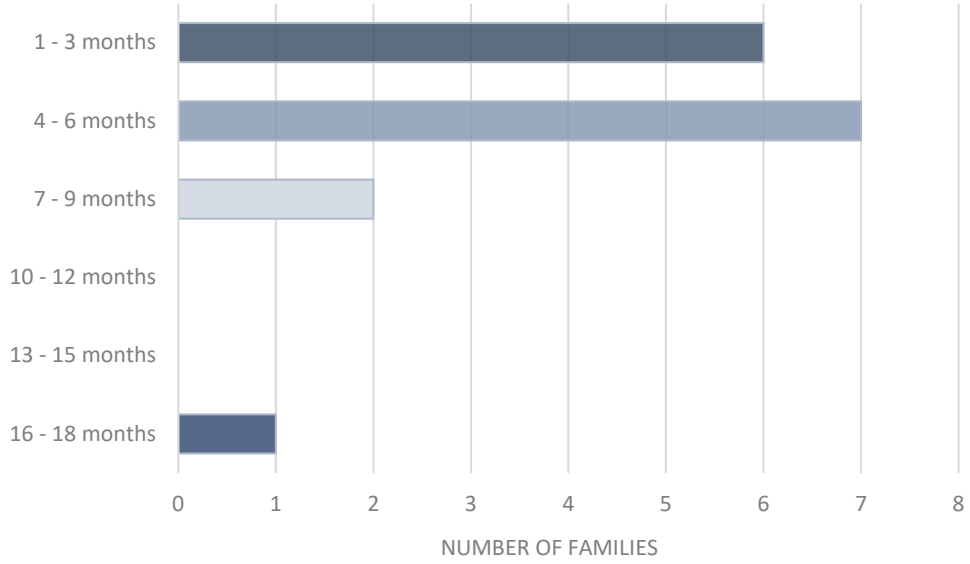
- Who are the hidden families being provided a service by WSSSA and have child protection concerns?
- What work is being done inside a women's shelter to support children and their mothers who have experienced domestic and family violence and associated children protection concerns?

Sample

A purposive sampling approach was employed to select the cases (Neuman 2013). The inclusion criteria for the case files were families who were residing and/or receiving services by WSSSA and children experiencing abuse and/or neglect because of domestic and family violence. Furthermore, that there was some DCP involvement or requests for WSSSA involvement to respond to the care and protection issues for the children. Data was collected for 20 families however analysis revealed that three of the twenty families did not meet the inclusion criteria. The case files of 17 families were reviewed and analysis included in this report. The identification of the families was dependent on the knowledge of practitioners who were working in the women's shelter. Files included in the study dated between March 2019 and September 2021. Figure 1 provides information as to how long the families were actively receiving intervention from WSSSA.

Figure 1

Length of Time Families were Involved with WSSSA



It is important to note that seven of the families continued to be actively involved with WSSSA at the end of the data collection stage. The findings indicate that, at the time of data collection, families were more likely to be in receipt of services between one to nine months making the women's shelter an important space to establish safety, security and implement therapeutic and practice strategies for both women and children to address the impacts of domestic and family violence.

Procedure

Case file reviews (Humphreys and Healy, 2017) were used to collect data about the families, to provide minimal intrusion and impact on families and workers. Data was extracted from the case files by the researchers using a data collection instrument (Appendix A). This instrument was co-constructed by the researchers and practitioners in WSSSA. The collection of information using the data collection instrument was developed to promote consistency in collection and recording of data and enabled the researchers to identify patterns, themes and identify characteristics of the hidden family cohort and the work being done. The case file data was collected and stored using REDCap, which is a secure encrypted system managed by Flinders University.

Prior to the collection of data, the researchers pilot tested the data collection instrument to ensure that there was consistency of data collection across team members and there was consistent understanding of the protocol for applying the instrument (e.g., a common understanding of the definitions/terms related to collaborative practice contained in the tool). The instrument was refined as part of the data collection process (e.g., definitions were amended and the protocol for inclusion/exclusion, etc. revised). Data was collected on site by a member of the project team who accessed the case files. This also ensured minimum disruption to the day-to-day work of the practitioners.

Data Analysis

The data collected from the case file reviews were analysed through seeking to answer the following specific questions:

1. What are the characteristics of the children and families who were identified as “hidden families”?
2. What were the experiences of the children?
3. What was the involvement of DCP? What was the involvement of WSSSA?
4. What were the identified risk and needs of the family and in particular the children?
5. What interventions were provided to the children and by which agency?
6. What factors promote or impede collaboration?

Focus Group

Two focus groups were held with nine shelter workers representing WSSSA. The purpose of the focus group was to hear how they understood the ‘hidden families’ and how they worked with such families, including enablers and barriers to such work, and collaboration with DCP. The data from the focus group was analysed using a basic thematic analysis, drawing out the major themes of the discussion and are included in the findings below were relevant to support the themes of the case file review.

Ethics Approval

The research project was approved by the Social and Behavioural Human Research Ethics Committee at Flinders University and the Aboriginal Health Research Ethics Committee in South Australia.

Findings

Below we present the findings from the case file review and focus group, reporting on the demographics of families, the intersecting complexities including the impact of domestic and family violence on women and children's lives, service provision offered by the women's shelter, the enablers and barriers to collaboration between the shelter and DCP, and finally we present assessment of risks.

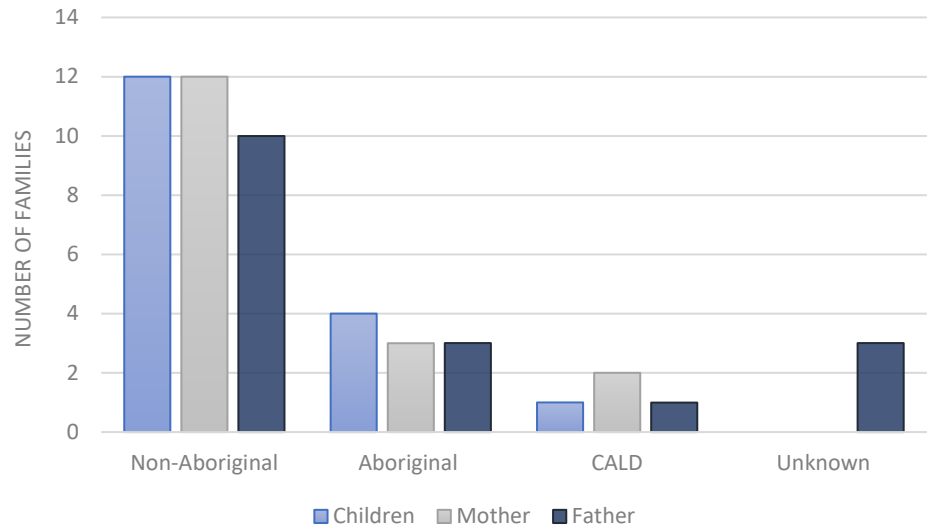
Demographic Information

Cultural Background

As demonstrated in Figure 2, of the seventeen case files reviewed, 12 families (70.6%) included women who were non-Aboriginal, 3 families (17.6%) included women who were Aboriginal, and 2 families (11.7%) included women who were identified as from culturally and linguistically diverse backgrounds (CALD). Similar findings were recorded for the children. Of the seventeen families, 12 families (70.6%) included children who were non-Aboriginal; 4 families (23.5%) included children who were identified as Aboriginal, and 1 family (5.9%) where children were identified as CALD. Of the seventeen families, 10 families (58.9%) included men who were non-Aboriginal, 3 families (17.6%) included men identified as Aboriginal, 1 family (5.9%) where men were identified as CALD, and 3 families (17.6%) where the males cultural background was unknown.

Figure 2

Cultural Identities of the Family Members

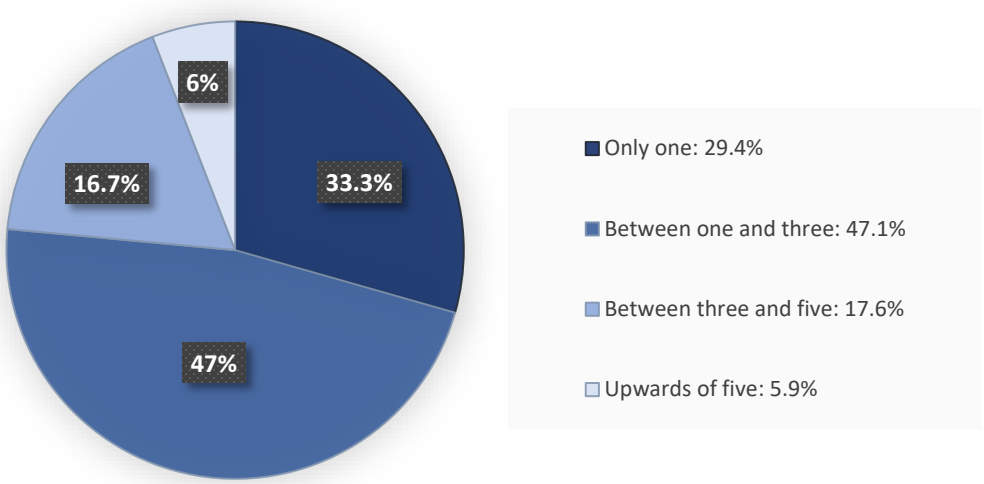


The Children

The seventeen families had 36 children in their care at the point of engaging with WSSSA services. Of the seventeen families, almost half 47.1% (n = 8) of the women had one to three children in their care, almost a third of the women 29.4%, (n = 5) had one child, and one fifth 17.6%, (n = 3) had between three to five children in her care. One mother had upwards of five children in her care. (See Figure 3)

Figure 3

Number of Children in the Care of Their Mothers

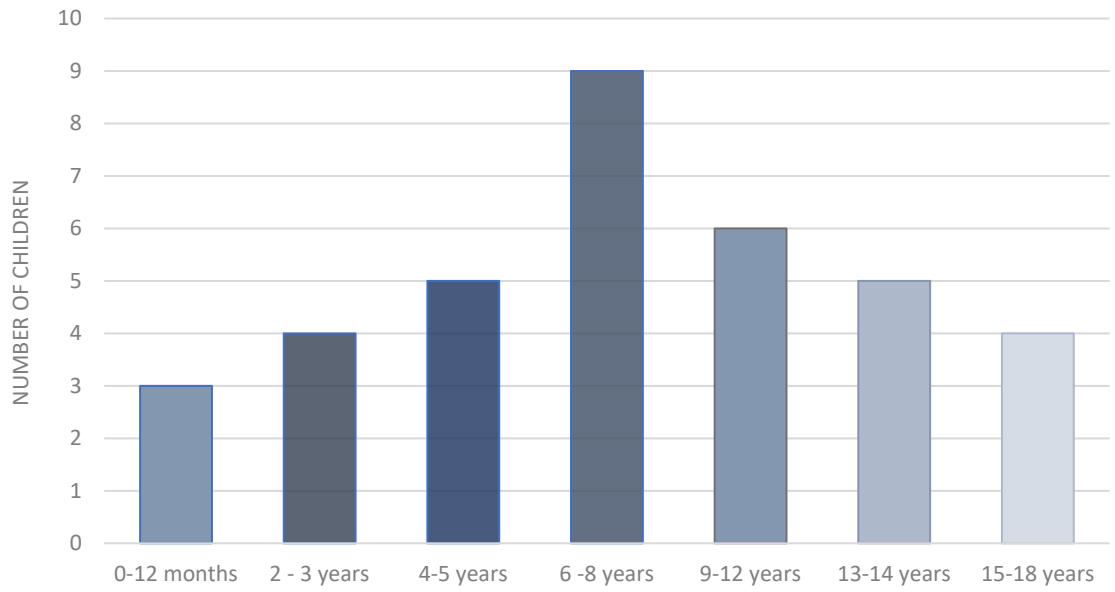


Of the seventeen families, it was identified that eight (50%) women had other children however they were not residing with them when they sought services from WSSSA.

Figure 4 summarise the ages of the children. Of the 36 children, 9.7% (n=3) were under the age of one, 13% (n=4) between the ages of 2 – 3 years, 16.1% (n=5) between the ages of 4 – 5 years, 29% (n=9) between the ages of 6-8 years, 19% (n=6) between the ages of 9-12 years, 16.1% (n=5) between the ages of 13-14 years, and 13% (n=4) 15 years and over.

Figure 4

Ages of Children



Relationships

The findings indicate that all the children were in the care of their mothers who were in receipt of services from WSSSA. However, analysis of data indicated that the relationships of the children to the alleged perpetrator/s were less straight forward as some sibling groups had different biological fathers.

Of the seventeen families, 76.5% (n=13) had experienced violence from a single male perpetrator, and 23.5% (n=4) violence was perpetrated by more than one male. There were some specific examples that warrant further consideration highlighting the complex lives of these children.

- A child (F53) aged between five and eight years old, was reported to have experienced violence from three males in their life: the mother's ex-partner, the mother's ex-partners 'best friend', and an older boy (aged ten at the time) who attended the same school.
- For another child (F48), three adult males were identified as perpetrators of violence – one of whom was the biological father of one child within the sibling group.
- In another family (F46), a child within a sibling group was identified as experiencing sexual abuse from the mothers' ex-partner and physical abuse by the mother.

Complex lives, intersecting challenges

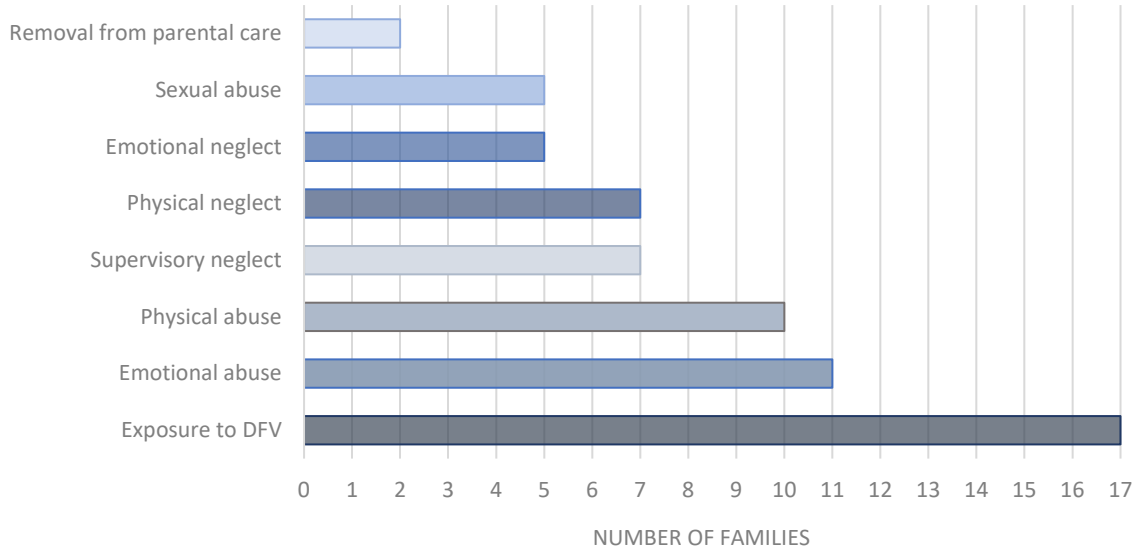
Domestic and family violence often occurs in a context of complexity in which women, children and the perpetrators of violence are likely navigating multiple and intersecting factors and competing challenges – hence they often have child protection services in their lives. Analysis of data relating to the seventeen families in this study is reflective of this complexity with many of women, children and male perpetrators experiencing multiple, intersecting hardships and risk factors that contribute to profound trauma and adversity.

The Children: Significant Trauma and Impacts

Figure 5 shows the abuse and neglect experienced by the children. The experiences identified share similarities with the categories of harm used in the child protection system. Of the seventeen families, children most experienced emotional abuse (64.7%, n = 11 families), then physical harm (58.8%, n = 10 families), followed by supervisory neglect (47.1%, n = 8 families), physical neglect (41.2%, n = 7 families), emotional neglect (29.4%, n = 5 families) and experiences of sexual abuse (29.4%, n = 5 families).

Figure 5

Children's Experiences of Maltreatment

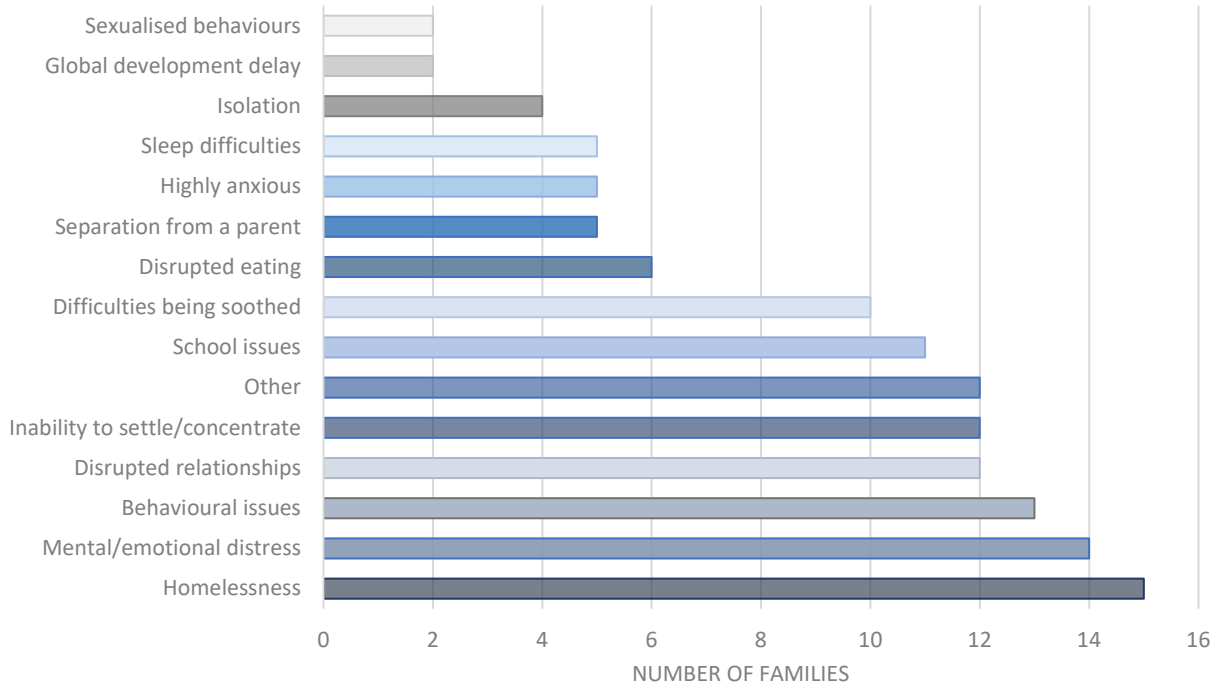


Whilst assessing formal categories of abuse and neglect is important in understanding the wide-reaching impacts of domestic and family violence, they do not provide insights into the impact and the trauma

associated with these experiences. Figure 6 reveals more in-depth information about the impact of trauma experienced by the children. The categories of experiences were developed in consultation with practitioners and another case file reading conducted by Bastian & Wendt (2022).

Figure 6

The Impacts of Trauma on Children



These findings indicate that children and young people who are in receipt of intervention in the context of women's shelters have high and complex needs. Most of the children experienced homelessness (15, 88.2%), followed by documented behaviour issues (withdrawn; aggressiveness; fearful) (13, 76.5%); mental/emotional distress (i.e. bedwetting; soiling (14, 82.4%); school issues (non-attendance; poor performance); disrupted relationships (12, 70.6%); inability to settle or concentrate (12, 70.6%); learning difficulties) (11, 64.7%); difficulty to be soothed (10, 58.8%); noted eating disruptions (6, 35.3%); highly anxious (5, 29.4%); Separation from mother and/or father (5, 29.4%); sleeping difficulties (5, 29.4%); Isolation (4, 23.5%); global developmental delay (2, 11.8%), and sexualised behaviour (2, 11.8%), The "other" category provides insight about the additional impacts of trauma experienced by the children across (70.6%) 12 families including disrupted sibling relationships and separation anxiety, maternal alienation, parent-child conflict, self-harm and suicidal ideation, parentification of children, diagnosis of

PTSD, risk taking, and engagement in criminal behaviours.

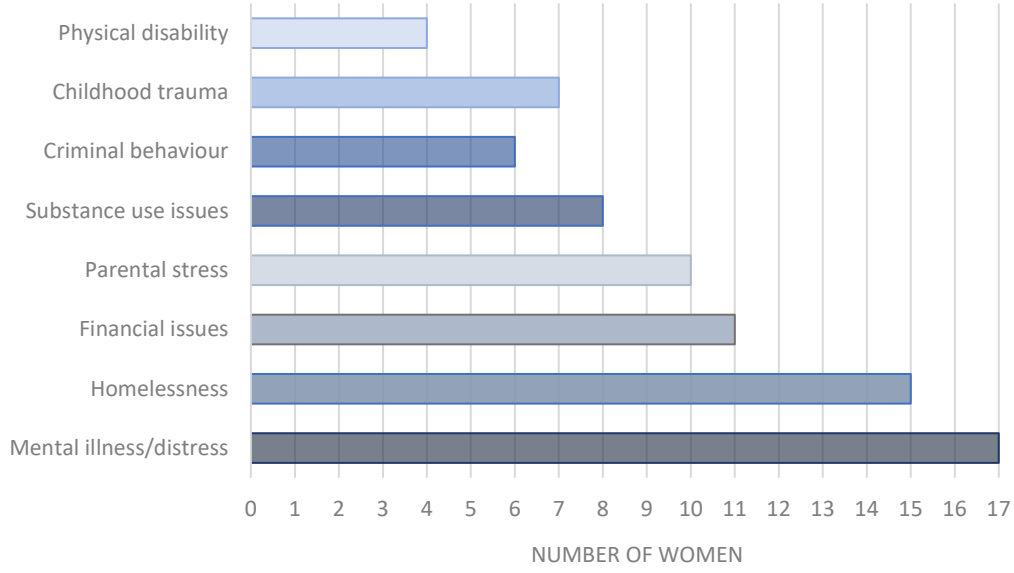
Additional findings were identified. The children from fourteen families remained living with their mother for the duration of their involvement in the women's shelter however other children, particularly older children, were separated from their mother and siblings. In one family, a child aged between 12-14 years remained in the care of the perpetrator and another child, also aged between 12-14 years, refused to stay with their mother in emergency accommodation "due to threats from perpetrator". This child chose to reside with their extended family while their mother was in emergency accommodation. In two of the families (F61 and 45), DCP formally removed children from the care of their mother due to ongoing safety concerns for the children whilst remaining in the care of the mother.

The Women: Intersecting Challenges and Hardships

Consistent with other research findings, all the women in this study who experienced domestic and family violence were also experiencing intersecting challenges and hardships at the point of seeking support from WSSSA. All the women experienced mental ill health or distress, including depression, anxiety, self-harm, suicidal ideation, schizoaffective disorder, post-traumatic stress disorder and sleep difficulties. It was also found that fifteen of the women (88.2%) experienced homelessness as they sought refuge from the violence. Experiences of homelessness were complicated by other pressures including financial hardship (64.7%), parental stress (58.8%), drug and alcohol issues (47.1%), childhood trauma (41.2%), criminal behaviour (35.3%) and physical disability (23.5%) (See Figure 7).

Figure 7

The Experiences of Women



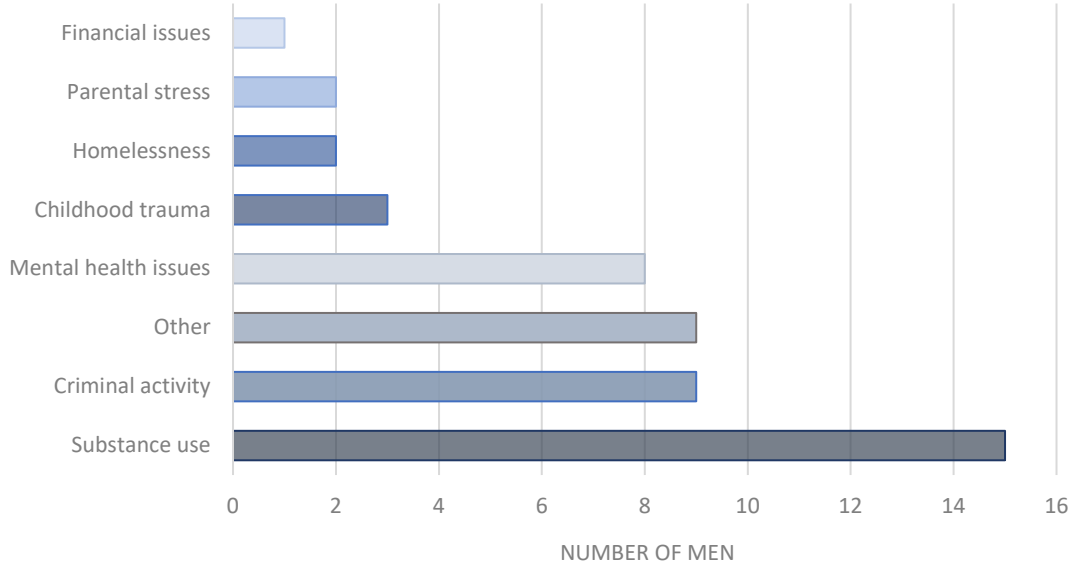
Qualitative responses further elucidate the complexities of the lives of the women. For example, responses indicate that nine women (53%) experienced ongoing physical health issues, and in six of these cases physical health issues (such as angina, physical injuries and/or chronic pain) were explicitly identified as the result of DFV. Four women (25%) were identified as experiencing isolation and/or alienation from supports, including family members, children, and friends. In one case, a woman reportedly communicated experiencing a sense of being overwhelmed by the number of services involved in her life.

The Men: Violence in Multiple Settings

The narratives about the men were found to be limited in comparison to the women and children. The available information indicated that there was high prevalence (88%) of drug and alcohol issues for the men who were identified as using violence. In addition, men were involved in criminal activity (53%), mental health issues (47%), childhood trauma (17%) and homelessness (12%) (Figure 8). In addition, issues relating 'parental stress' and financial issues were also documented.

Figure 8

The Experiences of Men



Further insights into the lived experiences of some of these men were identified. Of the seventeen families, three men (17%) were identified as being the subjects of Intervention Orders as a result of violence used in previous relationships; one male (6%) was identified as a registered sex offender, one (6%) reportedly experiencing behavioural issues at school and significant DFV as a child, and one (6%) was reportedly diagnosed with sociopathy and psychosis.

Of the seventeen families, four (23.5%) were noted to have violence perpetrated by more than one male. This means that the women and children in these four families were subjected to violence by more than one male at the point of engaging with WSSSA. Some of the findings for three families (17.6%) indicate that the males lived experience and use of violence extended beyond the intimate partner relationship context and that use of alcohol and other drugs were evident together with engagement in criminal activity.

During the focus group, participants expressed some optimism that perpetrators were being discussed between WSSSA and DCP because of the effort to collaborate but expressed concern that this is slow and not translating to understanding impacts of trauma on women and their children.

"*The sharing expertise in the space and putting the visibility back on the perpetrator, so that I find has been happening…. I guess being able to see that in practice. Some DCP are engaging with our knowledge as DV workers about maybe how to go forward when dealing with a woman's safety in that space. Which is amazing because that's getting momentum… aware of his visibility in this space, his responsibilities".*

Service provision

As discussed, this project is part of a larger research agenda focusing on building collaboration the intersection of domestic and family violence and child protection. This section examines findings of service provision provided by WSSSA and by DCP and indications of collaboration at the intersection of these two services.

WSSSA Service Provision

The women and children in the seventeen families were recipients of services provided by WSSSA either through referrals by other agencies or they self-referred seeking refuge and safety from violence. Women and their child/ren may enter the WSSSA service system via different pathways including self-referral, referral from another part of the agency (e.g., DV crisis service), referral by another agency, referral through an informal support such as friend or family or assertive engagement where WSSSA are requested to make contact (e.g., Family Safety Framework). On entry to the service WSSSA staff will ensure the mother and child are safe through provision of accommodation, conduct a risk assessment, engage in DFV counselling, provide case management services based on need of the woman and her child/ren. Case management services are responsive to the needs of the mother and child/ren to re-establish their lives that is free of violence. Some of these women are also involved with the Department for Child Protection and they are required to engage actions to ensure that their children are either safe or can return to their care.

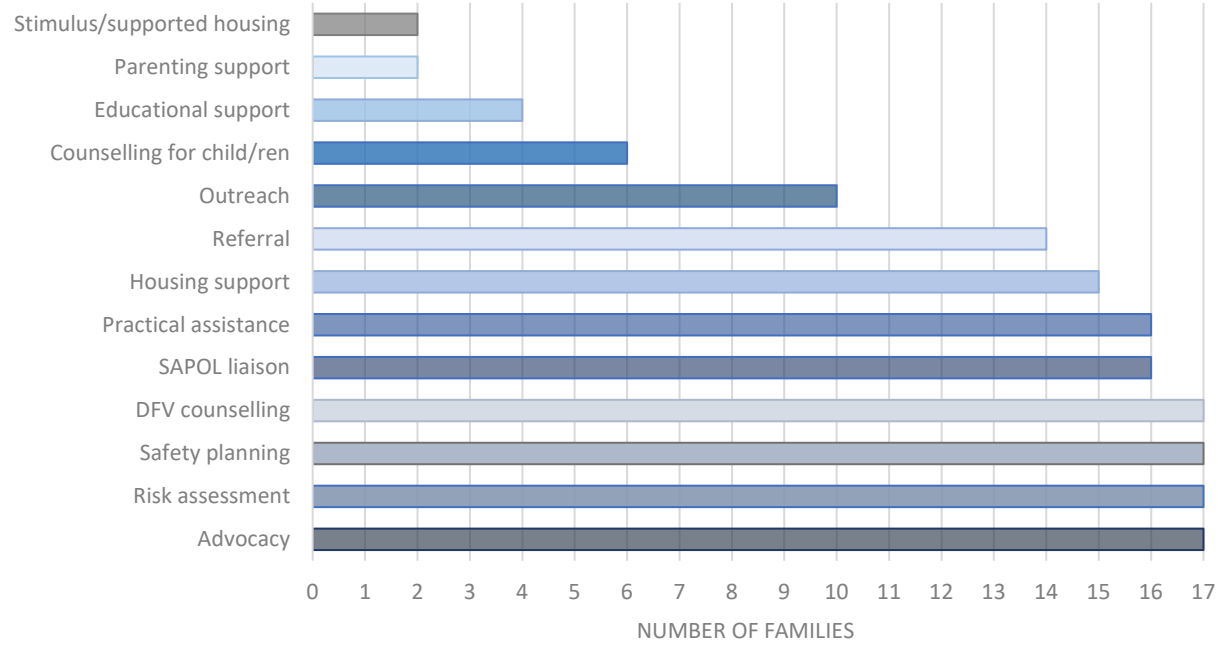
As depicted in Figure 9 the following services were provided to the women and their children:

- Of the seventeen families, all the women (100%) received advocacy, safety planning and risk assessment services.
- All women (100%) received domestic violence counselling whereas only one child (6%) was recorded as receiving domestic violence specific counselling.

- Of the seventeen families, sixteen (94%) of the families were provided with practical assistance specifically for the mothers whereas documentation indicates that women in fourteen of the families (82%) were provided with practical assistance to specifically address children's needs.
- Of the seventeen families, fifteen (88%) received assistance to secure housing and fourteen (82%) were referred to at least one external service and some of these referrals were made focusing on the needs of the children.
- Outreach support was provided to ten (59%) families and child specific counselling was provided to children across six families (35%).
- Four families (24%) were provided with educational support in response to the educational needs of the children.

Figure 9

Service Provision by WSSSA

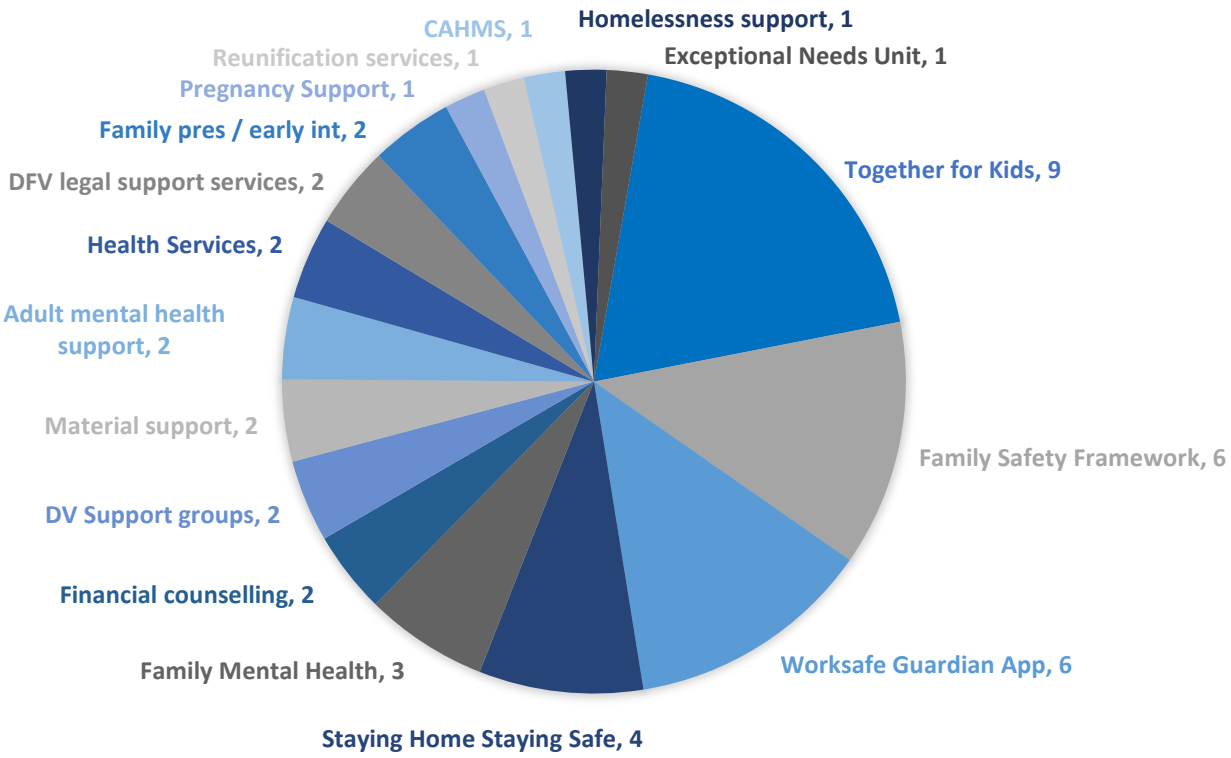


Information about the nature of the referrals made by WSSSA practitioners were captured for all the seventeen families (See Figure 10). Of the seventeen families, children in nine families (53%) were referred to a South Australian based service, Together for Kids, which is a child-focused wellbeing therapeutic program responding to children who experience homelessness and domestic and family

violence. It is unclear how many children this involved. The finding also demonstrates that most of the referrals were in response to the needs of the mother.

Figure 10

WSSSA Referrals



Families in Receipt of Services from Statutory Child Protection

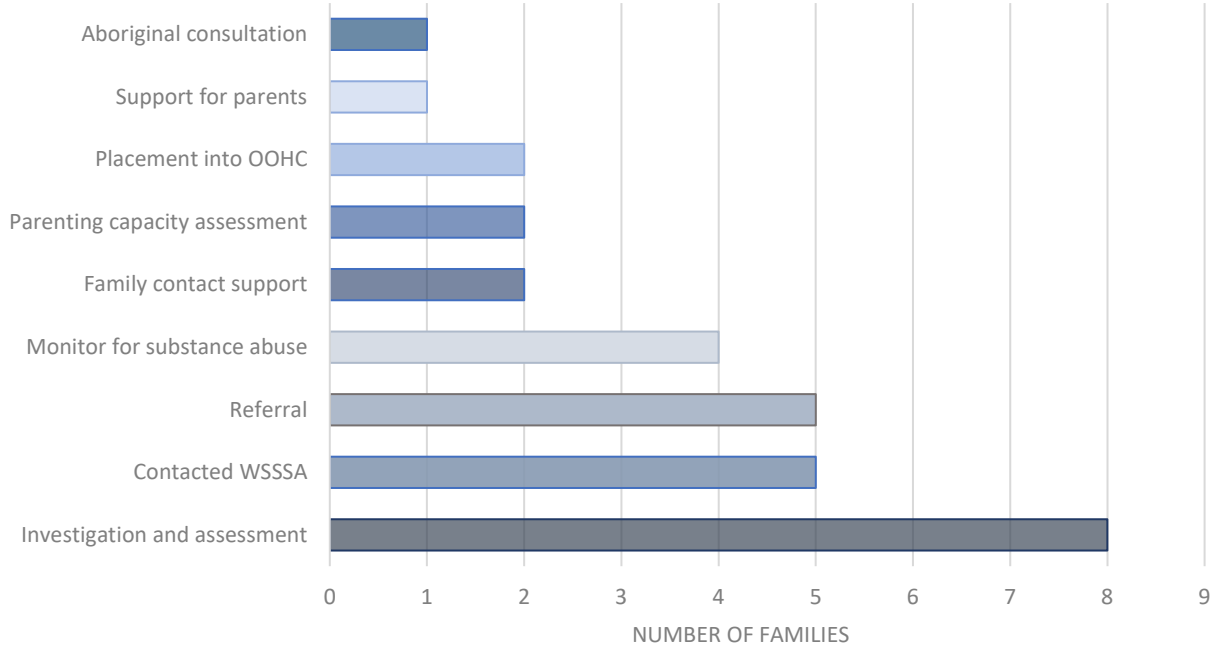
The previous section delineates the services provided to women and children within the context of the shelter in response to the needs of women and children who accessed the services of WSSSA. For some of those families, statutory child protection was also involved with eight (47.1%) of the families. Statutory child protection only becomes involved following the receipt of a notification and an assessment or investigation is only initiated if the circumstances meet the intervention threshold for statutory intervention where the children have been harmed or at risk of harm due to the presence of risk factors including domestic and family violence. The focus of child protection statutory intervention is to ensure the safety of the child through change of the family circumstances. Change in circumstances must ensure the safety of the child through reduction of risk factors (e.g., no longer living in a context of violence; safety planning to reduce violence; change in living arrangements) and increase in protective

factors (e.g., active engagement with services, mother and child seeking support, perpetrator visible and accountable; engagement of extended family members). In some situations, this also means that children need to be placed in care to achieve safety and security.

Findings (see Figure 11) indicate that DCP, as the statutory organisation, provided the following intervention or responses.

Figure 11

Service Provision by DCP



- The most provided response for all eight families was 'investigation and assessment'. Investigation and assessment involve the process of verifying whether a child has experienced harm or at risk of harm based on the allegations recorded.
- DCP made contact with practitioners in WSSSA who were working with the families to ascertain their level of involvement with five (29%) of the seventeen families.

- Referrals were also a common form of intervention. Referrals were made to other agencies by DCP for five families (29%). Of the five families, four of these referrals were to engage services for the mother, three for children. and one for the male perpetrator[1].
- DCP was involved in monitoring the use of drugs and alcohol for four families (24%) (four women and one male in total)
- DCP organised and/or supervised family contact arrangements for two families (12%), and organised parenting capacity assessments for two families (12%).
- Two children (5%) were placed into out of home care during the time they were involved with WSSSA in response to ongoing safety concern.
- Of the eight families who were in receipt of services from statutory child protection, two families (25%) received intervention to support parents and the children.
- Three (37%) of the eight families receiving a statutory response who identified as Aboriginal, yet there was no documented information as to whether this was in consultation with, or the involvement of, an Aboriginal practitioner in any of these cases.

A participant from the focus group reflected on DCP acknowledging the importance of collaboration with Aboriginal practitioners when Aboriginal families were receiving a statutory response, yet expressed frustration that it often did not occur because of a perceived lack of resources.

> *"There's a bit of strong commitment from First Nation staff to be present in the process and working with those cases that come through, but I think a significant challenge. And again, I think we're talking about resources. But that doesn't mean that's not what should be happening… So, remind Aboriginal staff at times in DCP around the cultural perspective, because I think they live in a very big machine – live and work in a very big bureaucratic machine that has a particular focus that don't forget to feed – feed the cultural aspect into that".*

It was found in focus groups that WSSSA at times disagreed with the assessment of risk and frustration was expressed at the perceived early closures of cases. For example, a mother and her children were referred to WSSSA due to a stepfather sexually and physically abusing the mother and the daughter. The

[1] DCP referred two families to the Anglicare Family Preservation team, one family to a Child Wellbeing Practitioner, one to KWY and one to Safer families. In one case, DCP organised a mental health assessment referral for a mother.

mother was also physically abusive towards the daughter. The children disclosed to the WSSSA worker significant harm from the mother and the mother's intent to return to her partner.

When the WSSSA worker raised this with DCP, it was explained the case needed to be closed because the mother has done the right thing by going to the shelter. The WSSSA worker also expressed dismay that the DCP would not talk to the children. The worker quotes the 12-year daughter saying:

> *"I've actually thought about this, and I think it's better if they do take me away because I'll be safer".*

Collaboration

The seventeen families were in receipt of services at the intersection of domestic and family violence and child protection and of those families, eight (47%) were in receipt of services from both agencies indicating that WSSSA predominantly provided the safety and protective needs of more than half of the mothers and their children. WSSSA, being a women's shelter, was not fully equipped to respond to the safety and wellbeing needs of children. There were situations where DCP's intervention was actively sought or requested due to identified and ongoing impacts of trauma to the children due to diminished parenting capacity, and the families may have benefitted from a collaborative approach. Analysis of information from case files indicated that there were missed opportunities for collaboration between WSSSA and DCP. Similarly, a focus group participant stated:

> *"When we are talking about child sexual abuse, we're talking about quite severe physical abuse, those situations still need DCP involvement and WSSSA is not going to solve that. DCP have resources which could be facilitated, for example, DCP have access to child psychologists you know, all these other resources they can tap into for children in their care… we don't have access necessarily or funding necessarily for those resources. So, the collaborative practice is critical in those spaces, you know what I mean? It just can't be palm them off to us."*

The categories that were evidence of collaboration were identified in consultation with practitioners and informed by research conducted by the Bastian & Wendt (2022).

Of the eight families where both agencies were actively involved collaboration was evidenced through the sharing of information. This finding is consistent with previous research findings (Bastian & Wendt 2022). The depth and richness of information sharing processes varied significantly across cases.

- Of the eight families, there was evidence that practitioners across the services identified and agreed upon roles and responsibilities in providing services to seven families (88%).
- In four of the families (50%), regular professional communication occurred and was documented in case files.
- Three families (38%) were the focus of case conferences and there was evidence of shared decision making for two families (25%).

There was no evidence of collaboration for nine (53%) of the seventeen families. Information extracted from the case files indicates that WSSSA sought DCP involvement due to ongoing child protection concerns. This was evidenced through the making of notifications alleging harm experienced by the children, advocacy and information sharing during telephone communication. A worker from the focus group said:

> *"There is not collaboration, because often the decision is made to close, they're not going to give that time to have any collaboration or conversations, and it's been communicated in the past, there's a theme of this capacity issue, some of the cases that have been flagged the common theme is we're closing because we don't have capacity. We're closing because they're connected with you. Those are the two main themes that have been happening."*

One of the challenges at the intersection of domestic and family violence and child protection was the differing mandates and threshold of intervention for each organisation. Threshold for statutory intervention may not be reached if children are considered "conditionally safe". This means that the children were no longer living in a context of violence, and therefore safe while during their stay in the women's shelter. However, women's shelters are not equipped to work with highly traumatised children with high and complex needs particularly in circumstances where the mothers have diminished parenting capacity due to trauma. In these situations, there are missed opportunities for collaboration in situations where both services were required to ensure the safety of women and children. Lack of collaboration was a concern raised in the focus group particularly in situations where WSSSA staff provided clear information about the risks to the child/ren but the statutory agency did not concur with assessed level of risk or deemed children to be conditionally safe therefore not meeting the threshold for statutory intervention.

The following examples provide insights into the missed opportunities for collaboration:

- In some situations, there is a perceived lack of recognised domestic and family violence expertise provided by WSSSA at the point of DCP case closure due to level of high risk to children (F5; F46; F62)
- No response from statutory agency following WSSSA making a child protection notification alleging lack of safety for children (F37; F49) or request for statutory child protection intervention (F57).
- Evidence of sharing of information via telephone communication on two occasions across the two agencies however the conversations centred primarily around DCP advising they would not be opening a case for the family despite WSSSA's advocacy expressing concerns for the risk of harm for the children (F43, F48).
- Case closure by the statutory child protection agency without collaborative decision making. This occurred for an Aboriginal family who were provided outreach support by the women's shelter, and on this basis child protection decided to terminate their involvement even though outreach support was provided because of concerns about the safety and wellbeing of the child. Child protection still decided to close the case and make a referral to another agency (Together 4 Kids) who expressed they were not equipped to work with children where there was high risk of harm (F45).
- Case closure by statutory child protection was identified across several families. In some circumstances the statutory agency informed about case closure without any discussions or shared decision (F53) and in other situations case files were closed without notifying staff (F56) at the women's shelter or the family. In one situation they did however notify the male perpetrator (F56) which raised concerns for ongoing safety of the mother and child/ren.

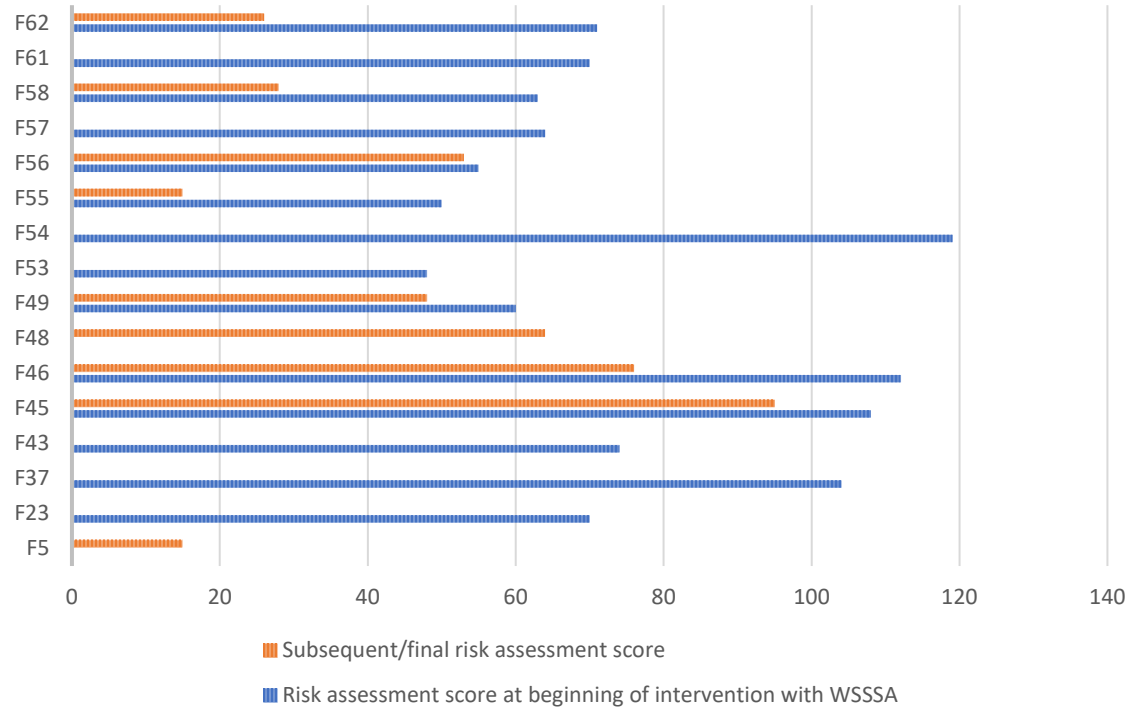
Assessed Risk of Families

When a woman and her family seek refuge from domestic and family violence and are accommodated in the women's shelter a risk assessment is conducted using the risk assessment used by the South Australian Family Safety Framework. The risk assessment includes questions to ascertain the following information including nature of abuse, historical patterns of abuse, the victim's perception of risk for themselves and their children, specific factors associated with violence (weapons, strangulation, coercive control), reinforcing behaviours (use of drugs, alcohol, financial or mental health issues), and other factors (pregnancy, separation, child contact, child vulnerabilities, legal processes in progress). Scores indicate level of risk and informs practice responses which fit into three categories: Standard (0 –

22), Medium (24 – 44), and High (45+). Risk assessment with a score of 45+ must include a judgement about imminent risk and whether a referral for a multi-agency response is required by the Family Safety Framework. It could be argued that if a child has been living in a violent context where risk is assessed as 45+ then involvement with statutory child protection is warranted. Figure 12 includes risk assessment scores for the seventeen families who are central to this analysis. All seventeen families had a risk assessment of greater than 45 when they sought refuge. Of the seventeen families, five (29%) had a lower score in subsequent risk assessments. It is also noted that subsequent risk assessment scores were not available for five families.

Figure 12

Risk Assessment Scores



Note: Initial assessment scores missing for F5 and F48. Subsequent scores missing for F23, F53, F54, F57, and F61

In reviewing the case file data, it was assessed that in 12 of the 17 cases included in the 'Hidden Families' project, WSSSA worked with families where risk was assessed to be extremely high. In three cases, risk was assessed as being shared equally across the services. In one case (F23), data was insufficient to determine which service held the most risk and in another, neither service was assessed

as carrying risk as WSSSA was not the lead agency, and instead played a DFV focussed advisory role, and DCP did not open a case.

Workers in the focus group also reflected on the assessment of risk, with a participant stating:

> *"How you manage risk, and different views about what that looks like across organisations, is a really interesting thing to unpack, and to look at. And how that then impacts on collaboration. I wonder too about common language, and how that's supports collaboration."*

Discusson

In answering the research question of who the hidden families are, receiving a service by WSSSA and have child protection concerns the findings showed that children are entering shelters with complex abuse and neglect as a result of domestic and family violence, and women experience complex issues due to their own long-term trauma, which in many circumstances diminishes their parenting capacity. It was found that the focus of statutory child protection is focused on addressing immediate harm to children and achieving safety through change of family circumstances, and women's shelters provided this refuge from the perpetrator. In answering the research question of what work is being done by the shelters to support such children and their mothers, it was found that women's shelters feel not resourced to work longer term with children experiencing complexities as victims of domestic and family violence, and to work with children and their mothers to establish safe parenting. In those situations where children and young people continue to experience high risk due to diminished capacity of the mother, WSSSA actively sought collaboration from DCP to manage and respond to such high-risk cases, with little success. The findings indicated that collaboration has been impeded by differing understandings and assessment of risk and the differing mandates and thresholds for intervention across the domestic and family violence and statutory context. These findings are important to note in terms of recent research that has explored children's responses and services in women's domestic and family violence shelters, seeking to advocate for greater resources to work with children and their mothers while they are present in such accommodation. The context provides an opportune time to establish safety to progress longer term trauma work but requires investment.

Research has established that domestic and family violence profoundly affects the mother-child relationship. Mothers have been found to be less emotionally available and less responsive to their child's needs, mothers may develop depressive, anxious, PTSD symptoms, which can lead to harsh, intrusive maternal parenting, and domestic violence can undermine the authority and control of non-abusive mothers, which may lead to children engaging in violent behaviour against them (van der Hoeven, 2023). Children who have experienced trauma associated with domestic and family violence need trauma-focused treatments with long term engagement. Women's shelters were traditionally established to provided victims of domestic and family violence safety through the provision of safe and temporary accommodation. More recently, there continues to be a high-level demand for these services but also include advocacy, support, and other forms of intervention (Chanmugam 2015). However, women's shelters receive limited resources and specific funding to respond to the mother, yet as this report and other research indicates (Bastian et al in press) there are increasing expectations and demand for practitioners in women's shelters to work closely with traumatised children with high and complex needs, particularly where the mother is struggling with her own trauma. Furthermore, children's connection with their perpetrator fathers usually does not end after they transition to a women's shelter, and studies have shown fathers often continue behaving violently such as during supervised visitations, custodial violence, and potential removal through child protection (Vass & Haj-Yahia (2022). This report found that there was some success in the collaboration to name the impact of the perpetrator's behaviour, but again there was no capacity to respond to this in meaningful ways for women and their children.

The reflections from the focus groups show, like other research, that shelter workers often feel a clash of values between feminist principles of working with the mother, and the realities of complexity when child protection concerns are present (including substance abuse, mental health problems, or aggressive behaviours from the mother). This may result in workers feeling torn between the desire to empower women and accept that the choices they make are best for them under the circumstances and having the children's best interests at heart (Cote et al 2022).

Research has shown that women's shelters can often only provide temporary care of children's safety and wellbeing while mothers are otherwise occupied trying to plan for their future. In some places this care to children can be provided by paid staff (if funding is available), but research has also shown this care is often done by volunteers - if such schemes are in place. This can be helpful but children's services in shelters should not be limited to such informality and ad hoc advocacy (Poole et al, 2008). It is

recommended that children require structured daily activities as a minimum service for children to provide safety, stability, and positive adult attention. To provide more services to children in shelters requires investment in a workforce who can provide child counselling, school integration, support for healing family relationships, trauma responsive behaviour management, adapting to change, screening and assessment of socio-emotional funding and appropriate therapy opportunities, and legal advocacy (Poole et al 2008). Research also advocates for resources in women's shelters to be able to work with children and mothers to repair, strengthen, and grow their bond. It has been shown that working with mothers indirectly helps children, as children need to trust that at least one parent is a reliable protector (Poole, et al, 2008). For collaboration to become richer and sustainable between statutory child protection and women's shelters, it needs to move beyond referral, insecure and informal arrangements, and expectations that meet the basic needs of children. The women's shelters are a readily available structure to ensure that children receive the necessary intervention to help break the cycle and trauma of domestic and family violence.

Resourcing, partnering, and building capacity within the existing structures and expertise within women's shelters to respond to needs of children victims of domestic and family violence has significant potential for collaboration with child protection. A recent systematic integrative review of research on children in domestic and family violence shelters (28 scientific articles published between 1984 and 2021 showed that overall, children feel safe at the shelters, and they appreciate the playgrounds and activities offered by the shelter. The studies also showed the importance of acknowledging children's rights to support, education, recreational time, and social relationships, to improve their life situation at the shelter (Thunberg et al, 2022). It is an opportune time as they are safe and present at a significant moment in their lives. Collaboration between women's shelters and child protection are therefore vital, so together they can assess and understand the impact of domestic and family violence on women and children's lives, and together shift their attention to the root cause of the problem in the children's lives (men's violence against women). Similarly, if they have concerns about a woman's parenting skills and capacity, they can support her as an alliance, prioritising her trauma recovery, and keeping view of the perpetrator's behaviours and such impacts on her and the children (Cote et al, 2022). It is an opportune time to build workforce and resource capacity within an existing service structure that is domestic and family violence informed and trauma responsive. Implementing a child centred and child informed workforce into women's shelters is perhaps the way to bridge collaboration between children protection and domestic and family violence.

Limitations

Time constraints only allowed for data to be collected for 20 families however of those, 3 families did not meet the inclusion criteria leaving a sample of 17 to be the final sample reviewed. This number can be considered low. This study, therefore, needs to be considered as exploratory and generalisations need to be made with caution. The case file review method is limited in that it provides only what is written for analysis and cannot provide context of practice. For example, just because something is not written in a case file does not mean it did not happen.

Recommendations

The findings and discussion contribute to the following recommendations:

- Implement a child-centred practice approach within women's shelters and employ additional specialist to enable the realisation of this work.
- Resource and build capacity in existing structures and expertise within women's shelters, which can enable specialist practitioners to respond to the needs of children and their mothers.
- Establish formalised collaborative links, such as a designated contact person in DCP, who can respond to women's shelter concerns of cumulative harm, rather than treating concerns as new and incidence-based concerns recorded through CARL.

References

Bastian, C., & Wendt, S. (2022), Collaboration between child protection and domestic and family violence: a case file review. *Australian Social Work*, https://doi.org/10.1080/0312407X.2021.2000627.

Chanmugam, A. (2015). Young adolescents' situational coping during adult intimate partner violence. *Child & Youth Services*, *36*(2), 98-123.

Cote, I., Damant, D, Lapierre, S (2022) Children in domestic violence shelters: Does the feminist perspective collapse? Journal of Social Work, 22 (2) 422-439.

Humphreys, C., & Healey, L. (2017). PAThways and Research Into Collaborative Inter-Agency practice: Collaborative work across the child protection and specialist domestic and family violence interface: Final report (ANROWS Horizons 03/2017). Sydney: ANROWS

Humphreys, C., Kertesz, M., Parolini, A., Isobe, J., Heward-Belle, S., Tsantefski, M., … Healey, L. (2020). Safe & Together Addressing Complexity for Children (STACY for Children) (Research report, 22/20). Sydney: ANROWS.

Neuman, W., Lawrence. (2013). Social research methods: Qualitative and quantitative approaches. Pearson Education.

Poole, A., Beran, T., Thurston, W. (2008) Direct and Indirect Services for Children in Domestic Violence Shelters, Journal of Family Violence, 23: 679-686

Tiesinga, H., & Berkhout, R. (2014). Labcraft: How social labs cultivate change through innovation and collaboration. Labcraft Publishing.

Thunberg, S., Vikander, M., Arnell, L (2022) Children's Rights and Their Life Situation in Domestic Violence Shelters—An Integrative Review, Child and Adolescent Social Work Journal, https://doi.org/10.1007/s10560-022-00900-1

Van der Hoeven, M., Widdershoven, G., van Duin, E., Hein, I., & Lindauer, R. (2022) A resilience enhancing trauma-informed program for children and mothers in domestic violence shelters: A qualitative study, Chid & Family Social Work, 28, 515-526

Vass, A. & Haj-Yahia, M (2022) The ambivalent visit: Children's experiences of relating with their fathers during staying in shelters for women survivors of domestic violence, Child & Family Social Work. 27:535–544.

Walters, M. (2013). Social research methods (Third ed.). Oxford University Press.

Wendt, S., Bastian, C. & Jones, M (2021) Building Collaboration with Child Protection and Domestic and Family Violence Sectors: Trialling a Living Lab Approach*, British Journal of Social Work,* 51,2, 692-711.

Appendix 5

Safe and Well Kids: An evaluation

July 2024

SWIRLS | Social Work Innovation Research Living Space

Dr Carmela Bastian
Dr Ali Elder
Professor Sarah Wendt

Flinders University | Social Work Innovation Research Living Space

Acknowledgements

This document has been produced by Social Work Innovation Living Space (SWIRLS) (July 2024) by Dr Carmela Bastian, Dr Ali Elder and Professor Sarah Wendt. We would like to thank the Department of Human Services for the provision of funding to conduct this evaluation. It is important to acknowledge and thank the staff in Women's Safety Services SA, Relationships Australia SA, Legal Services Commission and Department of Human Services who worked alongside us in conducting this evaluation and also for giving up their precious time to facilitate data collection.

Importantly we would like to acknowledge the women and children who gave us permission to read their case files and be allowed to read about their lived experience with the view to improve outcomes for other children and their mothers.

Contents

Executive Summary

Introduction

This report presents a review of the Safe and Well Kids program assessing whether short term outcomes as outlined in the program logic have been achieved for the fifteen families who agreed to participate in this research.

The Social Work Innovation Research Living Space (SWIRLS) was commissioned to undertake this review after one year of Safe and Well Kids implementation, to provide preliminary findings of its impact for children, young people and their families while the Program was still in development. This report details the outcomes for children and young people (and their families) who were in receipt of services from the integrated Safe and Well Kids Program.

The key objectives of the research review were to:

1. Identify the characteristics of families who have engaged with the Safe and Well Kids Program.
2. Map the interventions provided to the families by the Program.
3. Identify outcomes for the women and children who engaged in the Program, and
4. Provide recommendations for further development of the Program.

The review was co-designed and conducted in conjunction with staff from Women's Safety Services SA (WSSSA), the Department of Human Services (DHS), Relationships Australia SA (RASA), and Legal Services Commission (LSC) and demonstrates a commitment to engage in practice research to inform development of the service sector.

The review was structured to incorporate the expected short-term outcomes in the program logic during the data collection period 2022 – 2023 which were for:

1. Mothers to be empowered to make informed decisions (including legal decisions) about their own and their children's immediate wellbeing and physical/emotional safety.
2. Mothers to be supported to focus on, understand and notice their children's response to trauma.
3. Mothers and their children to receive the practical support required to restore safety.
4. Children to be provided with opportunities to make sense of their experiences, and mother to have a strong sense of their rights and,
5. Obligations within a legal framework are met and decisions made in the best interests of their children.

Methodology

An Advisory Group was established to provide the authorising environment for the research. The Advisory Group consisted of senior representatives from the Department of Human Services (DHS), Women's Safety Services SA (WSSSA), Relationships Australia SA (RASA), and Legal Services Commission (LSC). The Advisory Group met on a monthly basis, or as required to co-design the research process.

This review was qualitative in nature and utilised a case study approach to collect and analyse data in relation to fifteen families that included twenty-eight children. Information was extracted from case files using a data collection instrument that was developed in collaboration with the Advisory Group and practitioners who worked in the integrated program.

Key Findings

- The majority of parents in the cohort expressed feeling more confident as a parent; more connected to their children; more attuned to their needs; able to engage in discussions regarding the children's feelings, understand their behaviours; support them to regulate their emotions; and more able to set boundaries and attend to day-to-day parenting responsibilities.
- There was evidence of a range of improvements in most of the children's wellbeing, ranging from improvements in emotional literacy and regulation for both the mothers and their children; developing skills in recognising their emotions; and developing increased confidence and trust that their mothers would respond to their needs.
- In all the families there was evidence of strengthened family relationships, emotional safety, safety planning (including for visitations with father) and education and/or discussions about domestic and family violence.

- There was evidence that parents gained knowledge, understanding and preparedness about the legal health process.
- There was evidence of cultural connections and provision of culturally responsive services for both culturally and linguistically diverse and First Nations clients.
- There was evidence of enhanced professional networks and professional development opportunities.

This review took a holistic approach to reporting, recognising the importance of the integrated program delivery, rather than reporting against each service. This report aims to acknowledge all of the complex variables as a way to demonstrate the service delivery environment, and to acknowledge that any positive outcome within the short delivery period should be celebrated.

Recommendations

1. That this program continues, and adequate funding provided to ensure that children and their mothers who experience domestic and family violence are provided case management, therapeutic intervention, and access to legal services.
2. That the funding be flexible and responsive to the individual and unique needs of children rather than restricted to a specified twelve-week program.
3. The Safe and Well Kids program continue to enhance integration by establishing sustainable approaches for information sharing, shared decision making, and clarity about roles and responsibilities.
4. Additional research funding be provided so that the voices of children and their families be interviewed and in-depth qualitative information be included in future evaluation.

Introduction

Living in a context of domestic and family violence, witnessing the violence, being exposed to the violence, and subjected to tactics of coercive control is a recognised form of child abuse in Australia and is reflected in child protection legislations, policy and practice responses (Campo, 2015).

Australia is a signatory to the United Nations Convention on the Rights of the Child (1989) which articulates that children and young people have a right to be protected and be free of violence. *The National Plan to End Violence Against Women and Children 2022–2032* states that it is important to "recognise children and young people as victim-survivors of violence in their own right and establish appropriate supports and services that will meet their safety and recovery needs" (COAG, 2022, p. 21). *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* identifies that children and families with multiple and complex needs as a priority group. Children and families who experience multiple and complex needs includes those children who live in contexts of "mental health issues, alcohol and other drugs, domestic and family violence, disability, social exclusion, poverty, housing uncertainty, unemployment and underemployment" (COAG, 2021, p. 22).

Developing sustainable and effective interventions to respond to children and young people who live in a context of domestic and family violence requires urgent attention (Bastian et al 2023). In response to identified gaps in service provision for children and young people in South Australia the Safe and Well Kids Program was established, herein referred to as the Program. The Program was established by the Department of Human Services (DHS), as an integrated program between Women's Safety Services SA (WSSSA), Relationships Australia (SA) (RASA) and Legal Services Commission (LSC). The Program was the bringing together of three separate organisations moving towards an integrated model and implemented in metropolitan Adelaide to assist children and young people 0-14 years, whose mother/carer was receiving a service from Women's Safety Services SA (WSSSA). The aim of the Program is to divert children away from statutory systems and towards appropriate trauma informed and domestic a nd family violence informed therapeutic responses and legal supports.

After one year of the Program's implementation, Social Work Innovation Research Living Space (SWIRLS) was commissioned to under-take a review to ascertain preliminary findings of its impact for children, young people and their families. The review occurred in a context where the program was evolving and establishing its identity through increasing integration of three identified services. This report details client journey mapping of children and young people (and their families) who were in receipt of services from the integrated program. The purpose of client journey mapping enabled data to be generated about their circumstances at point of referral, interaction and intervention received, and outcomes achieved through involvement with the Program. These data provide an evidence base that is child-centred, family focused responses in the context of domestic and family violence. The review was co-produced with staff from Women's Safety Services SA (WSSSA), the Department of Human Services (DHS), Relationships Australia SA (RASA), and Legal Services Commission (LSC) demonstrating commitment to engage in practice research to inform development of the service sector.

The key objectives of the research review were to:

1. Identify the characteristics of families who have engaged with the Program.
2. Map the interventions, and outcomes provided to the families by the Program.
3. Identify outcomes for the women and children who engaged in the Program, and
4. Make recommendations about the future development of the Program.

Safe and Well Kids Program

The Safe and Well Kid Program was implemented in July 2021 as a pilot program in metropolitan Adelaide to assist children and young people 0 – 14 years, whose mother/carer was in receipt of services from Women's Safety Services SA (WSSSA). The aim of the Program is to provide trauma informed and domestic and family violence informed case management services, therapeutic services and legal supports to divert children away from the statutory child protection system. The program is not inclusive of fathers, however information about fathers is documented.

The structure of the Program is based on the roles of the program partners providing holistic services from point of crisis to therapeutic intervention to facilitate healing and recovery:

- Women's Safety Services SA provides children's case management for the Program and works with the mother through the standard service delivery case management,
- Relationships Australia SA provides therapeutic services for the children/young people, and
- Legal Services Commission provides legal advice and advocacy to support the best interests/needs of the child/young person and family.

The initial stages of the Program which began in July 2021, focused on bringing three separate agencies together shifting from separate to an integrated practice model and increasing referral pathways between the three organisations. A Program report in 2023 identified that the beginning stages of the integration was deemed successful as meaningful relationships with the children and young people were established. The early stages of integration of the three services resulted in increasing referral pathways and established relationships with children and young people however, the partner organisations identified the need for further work to ensure ongoing success. Identified issues that required attention were:

- Establishment of integration and joint working approaches with clients.
- Improved and increased level of co-ordination and information sharing between the partner organisations.
- Development of shared intervention plans.
- Clear timeframes for intervention.
- Improved data collection and increasing the voices of the mother/caregiver and children.

To address the identified issues and enhance integration the service model was reviewed and refined in July 2022 and effectively implemented in late 2022 (see Figure 1). The new model was inclusive of Case Conferencing (with all service delivery partners and the family) which focussed on the assessment and identified the needs of children and young people. The service model is based on a 12-week intervention period, where all parties work collaboratively with the family with meetings convened at 6 and 12 weeks to review case planning, interventions and outcomes. The model also incorporated regular practice meetings, organised by the Program Coordinator (new position) to enable a more formalised structure where service delivery partners could come together to discuss case directions, shared learning and collaboration. This a crucial component of any integrated partnership, ensuring ongoing relationship building, joint learning, and continuous improvement.

Safe and Well Kids Service Model 3.0

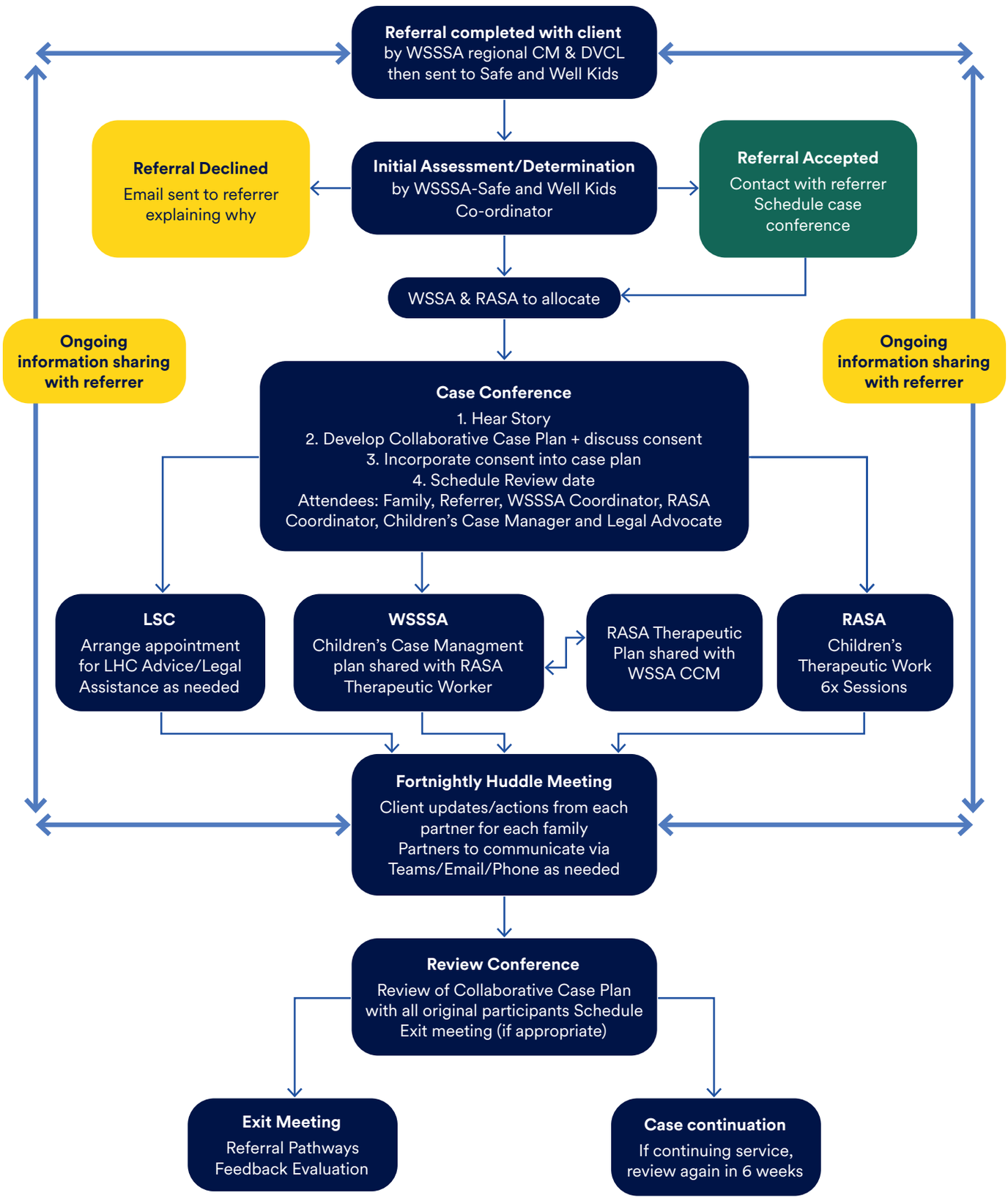


Figure 1 *Service model of the Safe and Well Kids program (July 2022)*

Aim

The primary aim of Safe and Well Kids is to improve the safety and wellbeing of children experiencing domestic and family violence through assessment and case management of their needs. The unique feature of the Program was to offer services from the point of crisis to enable children and young people to feel safe, stable and secure, so therapeutic intervention and access to legal services became possible early on in their journey of case management.

The objectives of Safe and Well Kids Program included:

- Ensuring child inclusive case management plans,
- Provision of safety planning management for mothers and their children,
- Therapeutic intervention for the children to address impacts of trauma,
- Provision of legal support and advice related to matters that impact on the children, and
- Developing an exit plan to ensure that mothers and children have ongoing support and access to resources.

Theory of Change

The theory of change for the Safe and Well Kids program was stated as:

> "the safety, stability and recovery of women and children impacted by domestic violence is secured through access to holistic and co-ordinated service responses that include a focus on the needs of children, the caregiving relationship, improved family functioning, legal advice and practice case management" (Safe and Well Kids 2023).

The short-term outcomes for the Program (as specified by the program logic) for the mothers and their children were outlined as follows:

1. Mothers are empowered to make informed decisions (including legal decisions) about their own and their children's immediate wellbeing and physical/emotional safety.
2. Mothers are supported to focus on and notice their children's responses to trauma.
3. Mothers and their children receive the practical support required to restore safety.
4. Children are provided with opportunities to make sense of their experiences, and mothers have a strong sense of their rights, and
5. Meet obligations within a legal framework and make decisions in the best interests of their children.

Service provision

The integrated service model of the Program has three key components including children's case management, therapeutic intervention, and legal advice and intervention. Below is a brief description of each component (See Figure 2).

Case Management

Women and children seek services from Women's Safety Services SA which is the primary referral source for the program. Referrals are made to the Program where child-specific crisis intervention and case management are required. Childrens case management offered by the Program is focussed on children and young people as clients in their own right, whilst the mother/caregivers receive case management from Women's Safety Services SA's other programs. Mothers/caregivers are consulted through all parts of the case management intervention as appropriate. The main areas of children's case management are:

- Children's needs assessments,
- Employment and education-focused support, particularly creating safe spaces to have conversations about the family's circumstances (both mother/carer and children),
- Domestic and Family Violence education and safety planning for children,
- Skill development,
- Advocacy, liaison and referrals,
- Inter relationship support between siblings, and
- Funding applications for equipment, mentoring support, recreational connections.

Therapeutic

One of the unique elements of this program is the provision of therapeutic intervention. Therapeutic work is provided by Relationships Australia SA. Children and their mothers/caregivers are given the opportunity to engage in therapy to understand the trauma related to the impact of domestic violence and improve their social and emotional health through strengthening bonds. The main areas of therapeutic work include:

- Provision of individual, family, dyadic and group therapeutic support for children and their

mothers/caregivers who have experienced domestic violence.

- Engaging with the mothers/caregiver to learn more about and strengthen positive bonds with their children where these relationships have been impacted by the domestic violence.
- Work with children to help them make sense of their experiences, understand their feelings, manage change, and improve their social skills.
- Help to restore a child's emotional and mental health through the improved relationship with their mother.

Legal

Legal Services provides child-centred advice to the mother and works with children independently where appropriate, providing warm referrals for mothers/caregivers where there is a legal conflict. Legal Services attempts to initially meet with the mother in person to foster a trusting rapport before diving into their legal needs. Legal Services introduces a 'Legal Health Check' tool to assist the mother, and/or referring case managers/workers, to identify any legal issues they may need assistance with. This tool is presented in simple terms, highlighting the main areas of law in which domestic violence and legal issues may intersect. Legal Services continues to monitor and assess families in the event circumstances change and legal issues arise, they can be dealt with expediently.

Legal Services provides information to mothers regarding the rights of the child/ren, empowering mothers to make informed and educated decisions around the safety of their children. Legal Services provides advice on:

- Parenting arrangements for children,
- Divorce advice/proceedings,
- Property settlements,
- Family court proceedings and processes, recovery orders, child support,
- Changing a child's name/amending birth certificate,
- Liaison with schools and care centres regarding potential for child to be taken,
- Legal aid applications,
- Intervention orders protecting the victim/survivor to enhance their safety,
- Child protection matters,
- Debt matters,
- Housing tenancy issues, and
- Court proceedings and criminal matters relating to charges against the alleged perpetrator.

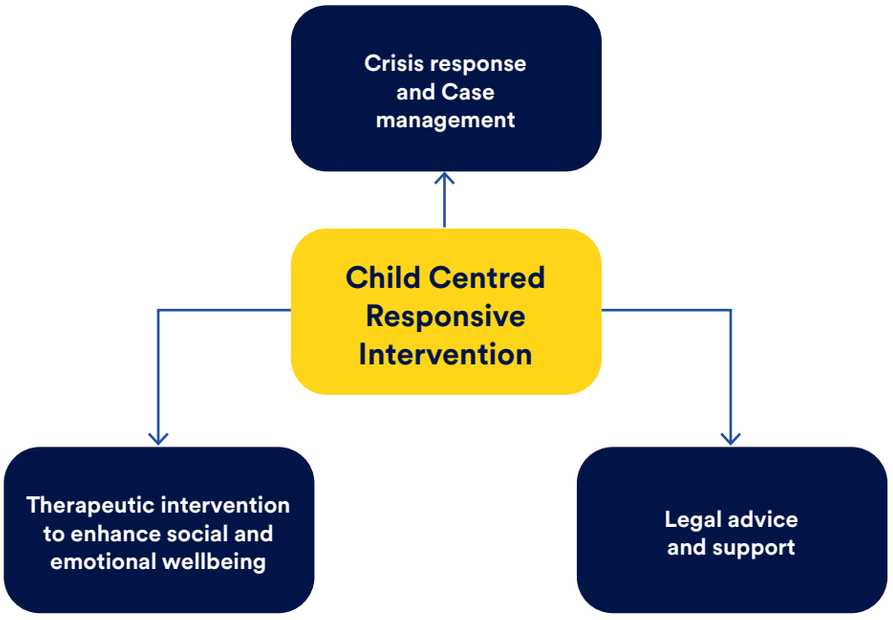


Figure 2 *Child centred and responsive intervention*

Methodology

The aims and theory of change together with the short-term outcomes were used to inform this review. The program logic also identified medium term and population level outcomes for women and children and the sector however measurement of these outcomes were out of scope for this review.

Modified Program Design

During the review period, there were some modifications to the Program but were not included as part of the program logic model and review parameters. These included:

- Program expanded from 12 weeks to 15 weeks including initial connection by the Program.
- Joint case plans were developed and implemented.
- Case conferences were replaced by initial meeting of family with coordinator and legal representative, or where there was a wait time, the legal representative would make initial introductions. This was changed in response to families feeding back that the case conference was overwhelming with so many people present.

Research Design

This was a qualitative research review design that adopted a case study approach.

A multiple case study design (Yin, 2012) was used to enable in-depth analysis of context-dependent knowledge and practice (Keddell, 2013). This was facilitated through a co-design and co-production approach which enabled the development of a data collection instrument to collect and analyse casefiles. A 'multiple case study' approach (Titscher, Meyer, Wodak, & Vetter, 2000; Yin, 2012) was used whereby information from fifteen case studies were extracted (See Figure 4).

Data was collected from the case files of women and children who were involved in the Program. The use of the mulitple cases of women and their children was not about reaching representation of the sector, but enhancing theoretical generalisations and understandings of complex interacting dynamics leading to an outcome. The case file of each family, or 'case study', was rich and complex, and analysis enabled knowledge development (Titscher, et al., 2000) about the journeys of women and children, their experiences of intervention in the Program and outcomes achieved. The outcomes for the children and young people were firmly at the centre of the analysis (Chambon, 1999). As a data source, analysis of case files 'bring detailed accounts of the experiences of some of the most stigmatised and socially excluded groups to the forefront of public awareness' (Stanley & Manthorpe, 2004, p. 1). The case studies included in this review provided a valuable vehicle through which learnings about processes or dynamics in operation was possible and can be potentially applied in other similar situations (Ackroyd & Karlsson, 2014, p. 24).

The project received ethics approval through the Flinders University Human Research Ethics Committee (Approval 5051).

The research design was in keeping with co-design ethos employed by SWIRLS. SWIRLS and the relevant agencies working in the Program contributed to finalisation of the research design (See Figure 3).

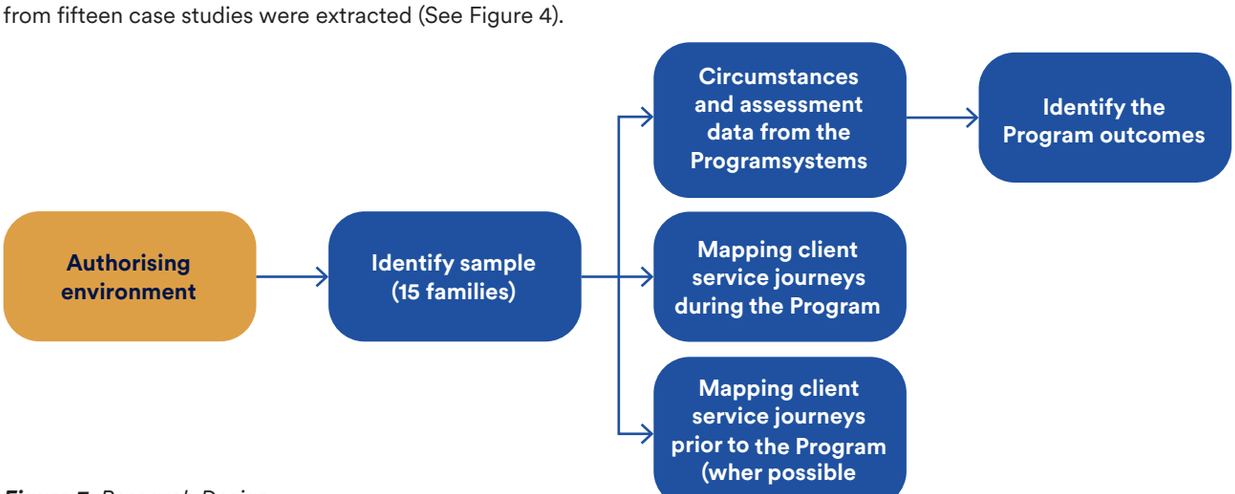


Figure 3 *Research Design*

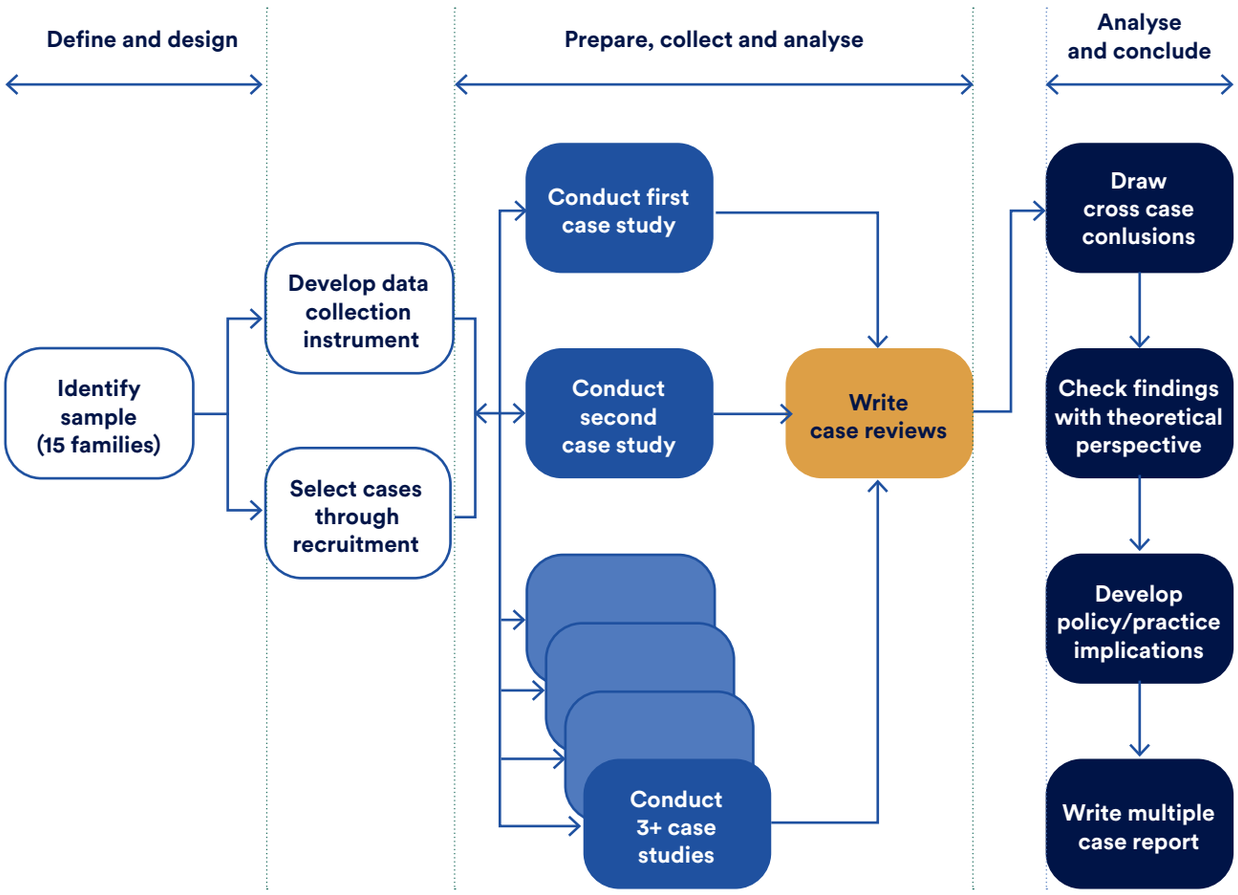


Figure 4 *Multiple case study Design (Yin 2012)*

Establishing an authorising environment

All aspects of the research project were overseen by an Advisory Group that formed the authorising environment. The term 'authorising environment', is derived from public value theory (Moore, 1995) and refers to the "legitimising of processes within and across systems. Collaboration within an authorising environment have clear expectations mandated by bodies – government and non-government – to whom the collaboration is accountable" (Connolly et al., 2017, p.7). The working group consisted of representatives from each organisation and the SWIRLS research team. The working group, as the authorising environment, was involved in the co-design of the research design, the mapping methodology, data collection instrument, processes for recruitment of practitioners, women and children, analysis and final recommendations.

Case file readings

Case file reviews (Humphreys and Healy, 2017) supported the overarching research agenda of co-designing and evaluating the journeys of children and their families involved in the Program. Data was extracted from the case files by the researchers using a data collection instrument (Appendix B). The data collection instrument was developed to promote consistency in collection and recording of data. This instrument was constructed by the researchers and informed by the practice wisdom of staff who worked in the Program. Case file data was collected and stored using REDCap, which is a secure encrypted system managed by Flinders University.

Prior to the collection of data, the researchers pilot tested the data collection instrument to ensure that there was consistency of data collection across team members and there was consistent understanding of the protocol for applying the instrument (e.g. a common understanding of the definitions/terms related to collaborative practice contained in the tool). The instrument was refined as

part of the data collection process (e.g. definitions were amended and the protocol for inclusion/exclusion, etc. revised). Data was sourced from a variety of documents that were included in the case files including intake referral forms, case notes, notes documented by the Program operational team, case reviews, case plans, therapeutic plans, and feedback provided by families at case closure. Having multiple sources of documentary evidence available in the case files enabled the researchers to collect a rich and comprehensive data to inform the evaluation. All of the available data has been collated for each family to create an individual case study vignette (Appendix A). In cases where there were some gaps in information and lack of clarity, the Program coordinator was contacted by the researcher.

The data was collected between March 2023 – June 2023 (4 months) by contacting the three services and requesting any information that was relevant to fill in the survey instrument. In most cases, data was entered into the collection instrument, then a narrative was created about each family.

Recruitment and sampling

A purposive sampling approach was used. The inclusion criteria for the case studies were families and their children who were provided a service through the Program. The recruitment of mothers/carers and their children was facilitated by the Program practitioners or program co-ordinator. The researchers dedicated time discussing the research with practitioners involved in the program engaging them in the process of recruitment and what was required for data collection. The practitioners discussed the research with the families using an information sheet provided by the research team. The practitioners sought the consent of the family's giving permission for the researchers to access the case files. At the beginning of the research project recruitment was slow however once a program co-ordinator was employed this enabled a speedier and more co-ordinated recruitment process.

The files of fifteen families were involved in this review with thirteen of the families recruited from the newly refined Program model which began in September 2022. Of the fifteen families, two families were in receipt of services from the Program prior to September but were re-referred into the refined model. This means that the findings outlined in this report are reflective of the service provided following implementation of the model after September 2022. Please see Table 1: for an overview of the sample.

Data analysis

The data collected from the case files and related documents were analysed using the following questions as a guide:

1. What are the characteristics of the families' provided services by Safe and Well Kids program?
2. What services were provided to the families?
3. What were the outcomes achieved for the women and children in receipt of the services?

Data was downloaded from the REDCap software into Excel spreadsheets, collated and analysed across all the fifteen families. Vignettes were written up for each family to further analyse more in depth understanding of the children and women's circumstances (See Appendix A).

Limitations

The research was conducted while the integrated program was moving through establishment of integration and under review. Due to some constraints and limited staffing resources, there was a delay in acquiring consent for families to be part of the case file review process. During the early stages of the program, the organisations involved were establishing an identity and functions from individual programs to be part of an integrated program. The program was working towards establishing more integrated systems including documentation available for each family.

There are also limitations in using case file data as primary sources of data. The information used for the review was dependent on the quality and consistency of records. The data available for this review was not always consistent. Inconsistencies were noted in the case file information due to the evolving nature of the program and changes of staff/case managers. This means that each case study data varies, making comparable claims between cases not possible at this stage of the program. However, when bringing all the case studies together, there was enough data to make some general claims about the impact of the Safe and Well Kids Program against the short-term program logic outcomes.

Family	Number of children	Accommodation at time of referral*	Length of time engage with Safe and Well Kids*
F1	Four	On site at WSSSA	24 weeks (2 referrals)
F2	Four	Motel	12 weeks
F3	Three	Transitional accommodation	12 weeks
F4	One (Two other children not with mother)	Motel	12 weeks
F5	One (Another child not with mother)	Emergency accommodation	12 weeks
F6	Two	Emergency Accommodation	24 weeks (2 referrals)
F7	Two	Emergency Accommodation	12 weeks
F8	Two	On-site	14 weeks
F9	One	Emergency Accommodation	12 weeks
F10	One	Emergency Accommodation	12 weeks
F11	One	On site	12 weeks
F12	One	Transitional	16 weeks
F13	Two	Emergency Accommodation	18 weeks
F14	One	Emergency Accommodation	17 weeks
F15	Two	Transitional	12 weeks

Table 1 *Families involved in research*

***Accommodation varies:** emergency accommodation (crisis accommodation); on site at women's shelter, and transitional is medium term accommodation waiting for longer term accommodation.

Findings

The Program is operating in a complex human service delivery environment. Mothers and children seeking support for domestic and family violence present to services with a wide range of complex issues which impact their lives to varying degrees, and this complexity shapes the way a service engages and delivers a program. Each child in the cohort presented with varying needs relating to the trauma, developmental stage, and interactions and relationship with the perpetrator and/or father. It is also important to acknowledge that each family presented with varying strengths, capabilities, and their own social supports, also shaping their abilities and readiness to engage with the Program.

All families were offered therapeutic support, practical case management and legal supports as part of the Program, and eleven families accessed all three. Some families accessed or engaged with one or two of these services due to their need, complex circumstances, or readiness/capacity to engage. The data provides evidence that attempts to engage the children and families was made by the program, and where engagement wasn't as successful, multiple attempts or revised engagement approaches were attempted. One example was when a mother became ill during the intervention and the children were returned to live with the father. During this time, the therapeutic work was adapted to be conducted with the mother, resulting in positive relationship building with the children upon their return.

Demographic information

Cultural background

As demonstrated in Figure 5, of the fifteen cases reviewed, four (27%) were from a culturally and linguistically diverse background, four (27%) were mothers and/or children who identified as Aboriginal, and seven (47%) were non-Aboriginal.

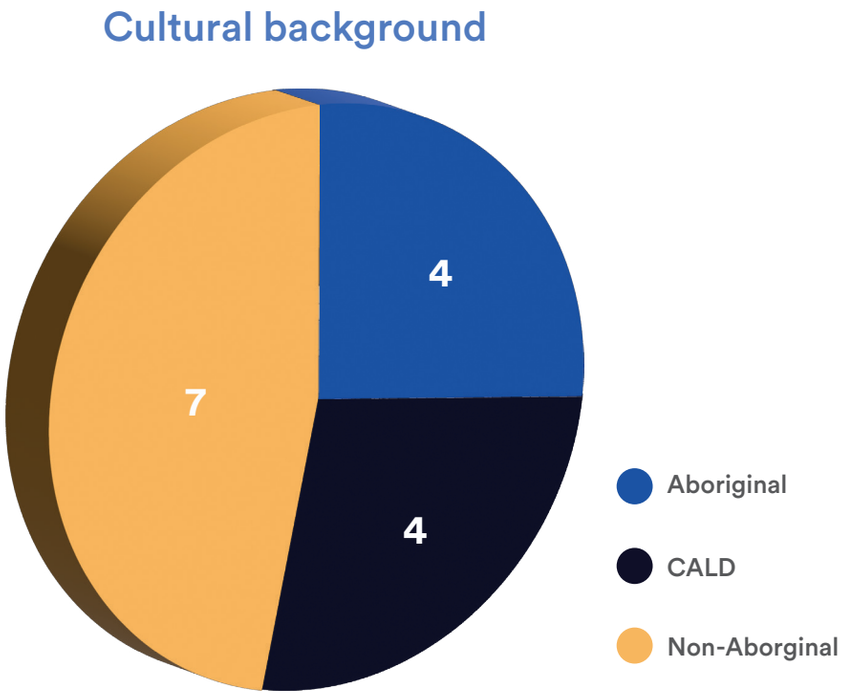


Figure 5 *Cultural background*

Information about the children

- There were twenty-eight children across the fifteen families. Of the fifteen families, six families (40%) had one child; seven (47%) had two children, and two (13%) had four children (See Figure 6).
- Of the fifteen families, three (20%) had other children recorded on the referral form, but they did not receive a service, or they were not living with mother at the time of the intervention. In addition, children of two families (13%) were placed in the father's care while receiving intervention from the program.
- Of the twenty-eight children who were in receipt of services from the Program, eighteen children (64%) were between the ages of 0 – 8 years and ten children (36%) were aged 9 years and above as demonstrated in Figure 6.

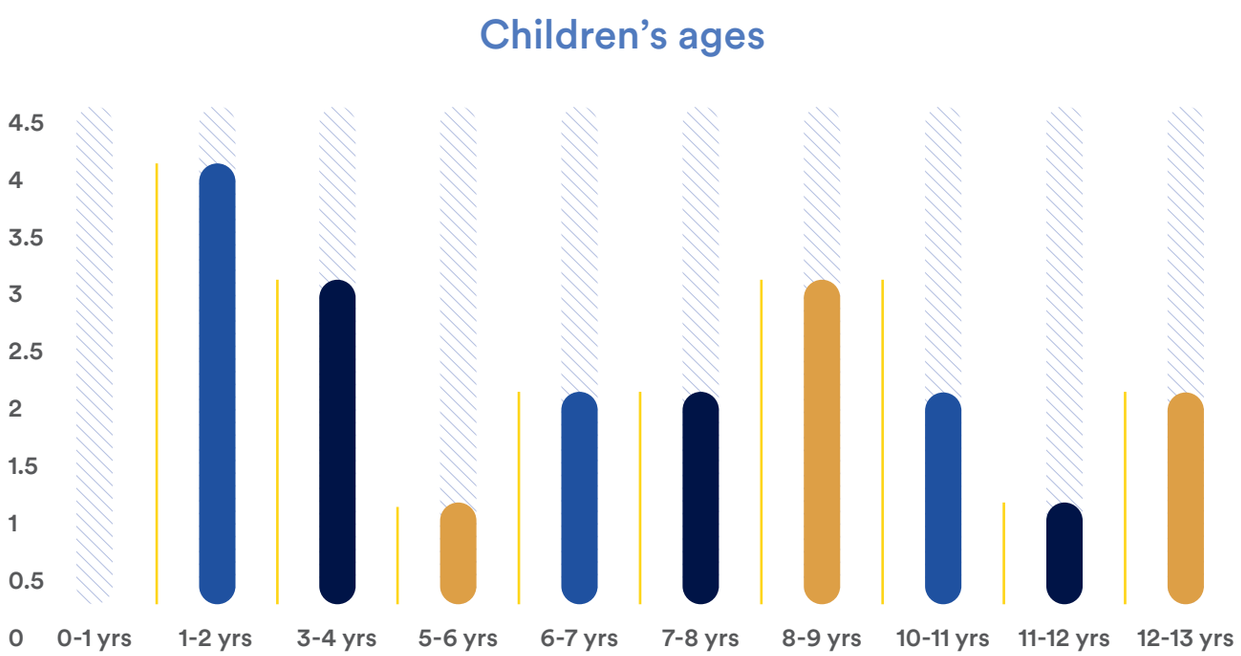


Figure 6 *Ages of the children*

Children's Experiences

As depicted in Figure 7, a range of categories of children's experiences emerged from the information extracted from the case files. Categories identified best described the experiences of the children, and their circumstances, which were available through assessment information recorded in the case file documentation. Some of the experiences identified were consistent with child protection categories but other experiences were also noted.

Of the twenty-eight children, twenty (71%) were noted to have experienced emotional abuse, and twelve (43%) experienced physical abuse. Other problems identified as follows: eighteen children (64%) experienced issues with school (i.e. non-attendance; inability to concentrate), thirteen children (46%) experienced behaviour issues including aggressive or withdrawn behaviour; ten children (36%) experienced disruption to eating; ten children (36%) experienced disrupted relationships; five children (18%) experienced mental distress; four children (14%) were identified as neurodivergent or having developmental delays (speech delays; autism spectrum disorder, auditory processing disorder), and four children (14%) had difficulties with sleeping.

Every child is unique in how they respond to experiences of trauma, and it is also important to note that some of the children experienced multiple issues that were detrimental to their social, physical and emotional wellbeing.

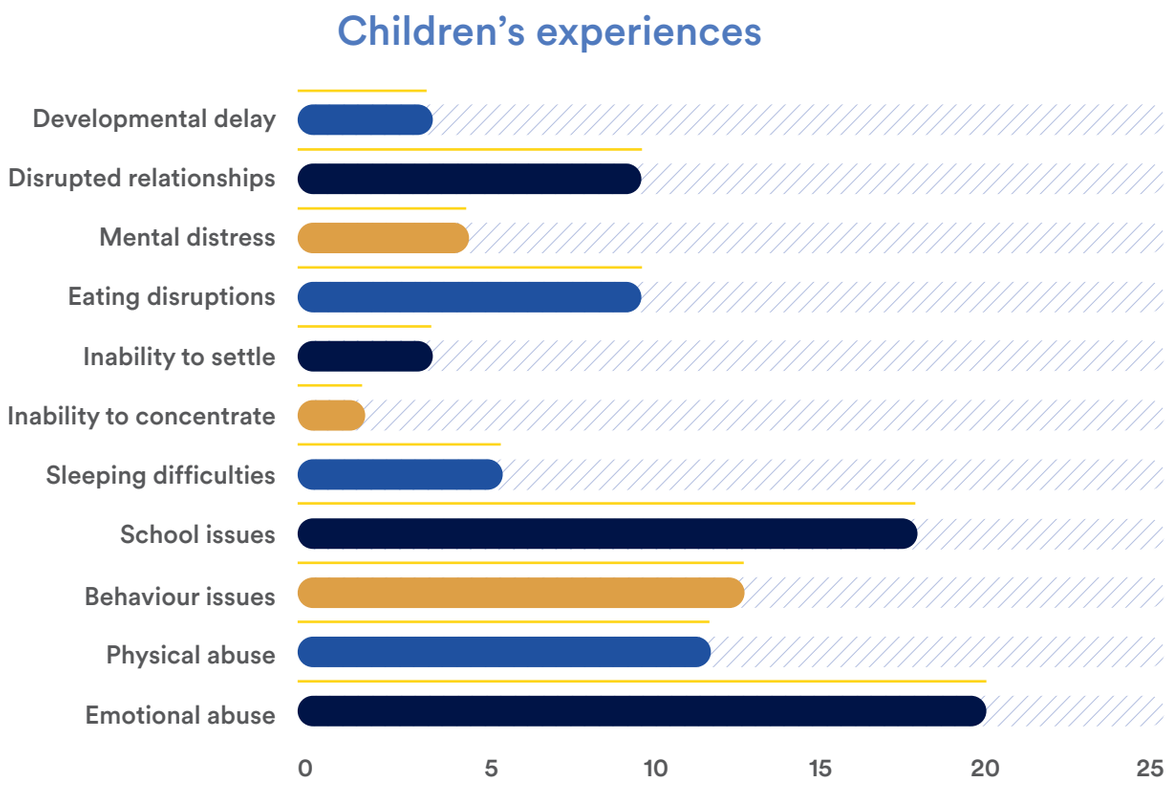


Figure 7 *Children's experiences*

Women's experiences

Through the intake process with case managers, all the fifteen women (100%) said they experienced trauma due to domestic and family violence and almost half had said they were suffering with mental health issues. Many of the women also said that they experienced social isolation, parental stress, homelessness and physical health issues and substance use that impact on their lives whilst living in a context of domestic and family violence (See Figure 8).

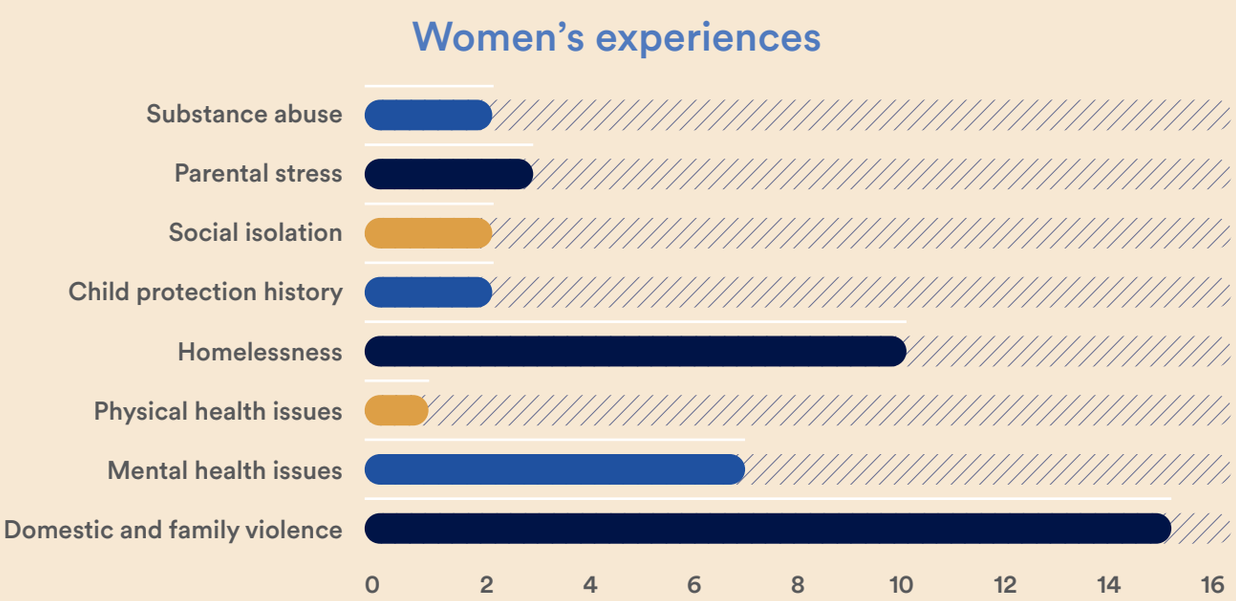


Figure 8 *Women's experiences*

Men's experiences

Information about the men's experiences was limited however, there was information about nine of the men who were identified as the primary person perpetrating violence (see Figure 9). Of the fifteen families, almost a third (27%) had more than one-person perpetrating violence against the women and the children. All the nine men (100%) had demonstrated experiences of perpetrating domestic and family violence. Of the nine men additional information available in the case files identified that more than half of the men (n=5; 55%) experienced mental health issues and substance abuse issues, and one man (11%) was known to engage in criminal activities in addition to perpetrating violence. The other category includes that some men were engaging in ongoing threatening and harassing behaviour and refused to return children following family contact.

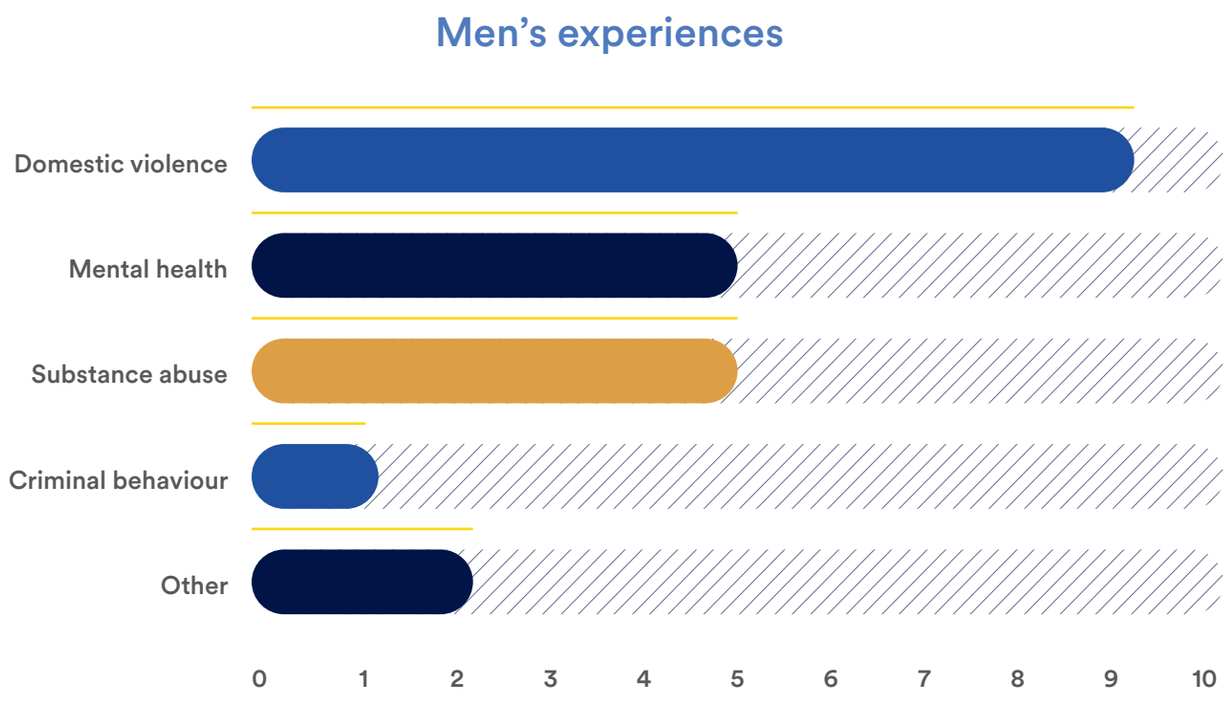


Figure 9 *Men's experiences*

Services provided by the Program and Outcomes.

As noted earlier in this document the Program provides case management for children and their mothers, therapeutic intervention, and provision of legal support and advice. Service providers were reflective of the holistic approach provided by the program. Child centred services not only engage in activities focusing solely on the child's needs but also engage in intervention with their mothers to ensure they are provided with nurturing relationships, provision of protection, and basic life necessities.

Case management services

All families received case management services inclusive of the mother and the children. Case management activities with the mother enabled practitioners to build a professional alliance with them. Howe (2010) argues that building an alliance with a parent and keeping them in mind by practitioners "makes it safer for the parent to think about the child who is therefore not only more likely to be in mind but also in sight, and as a result a bit safer" (p. 337). The review of case files found an array of activities provided to the family as outlined in Figure 10. The range of activities identified through analysis of case file information are consistent with the case management categories articulated in the program documentation. All families (100%) received services to access appropriate accommodation after seeking refuge from domestic and family violence. Of the fifteen families in the the Program, fourteen (93%) were in receipt of counselling and education about domestic and family violence and thirteen families (86%) were engaged in safety planning. Other activities involved making referrals for children to engage in behaviour assessments, links to services, practical support and access to necessary resources to support families in making change in their lives.

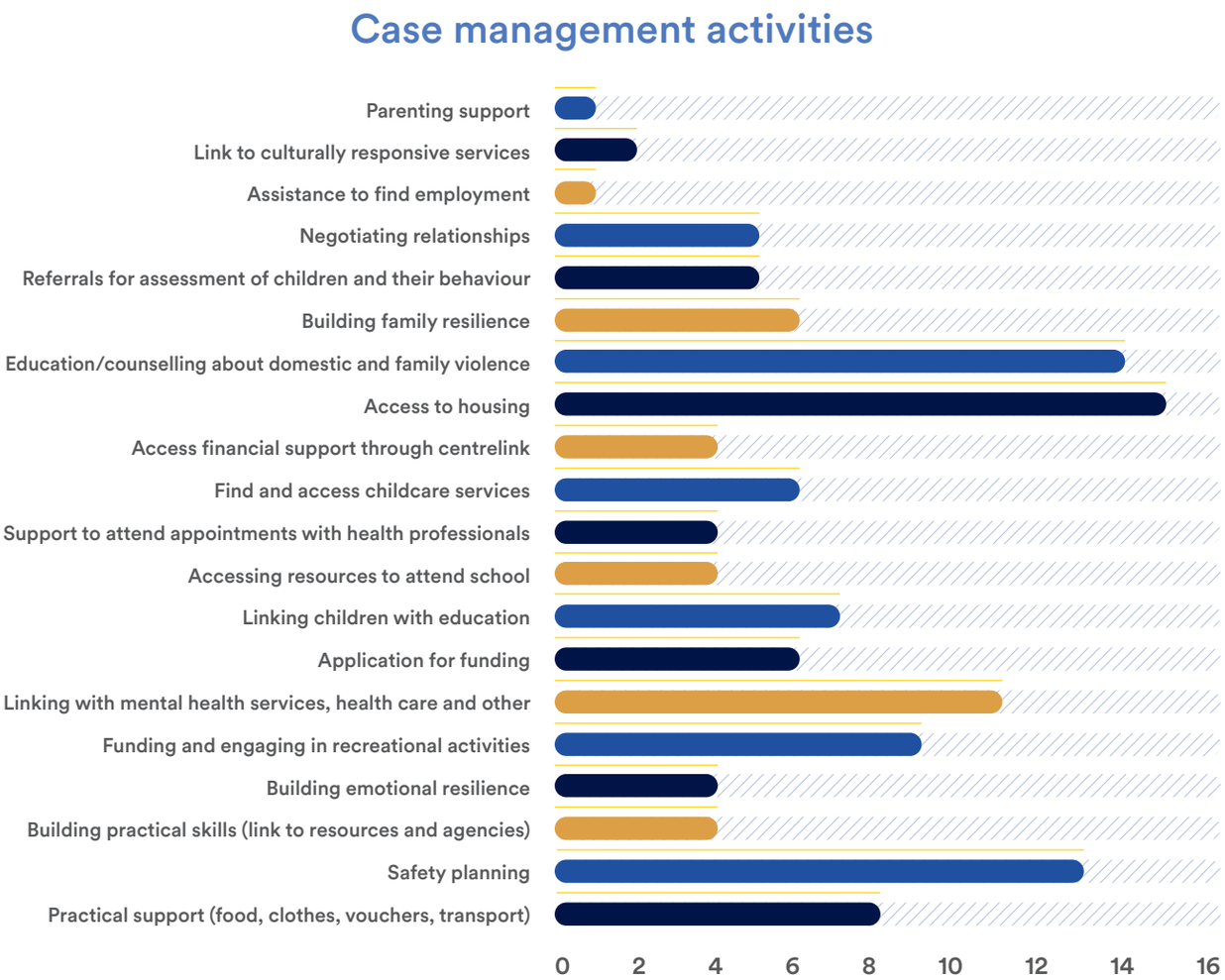


Figure 10 *Case management activities*

Therapeutic intervention

Figure 11 demonstrates the range of activities integrated into the therapeutic responses for the children and their mothers. As per the previous section, all the activities identified are consistent with families being provided with therapeutic support, activities to improve the mother child relationships, work individually with children to make sense of their experiences and build resilience, and enable children to recover from experiences of trauma. The therapeutic activities identified demonstrate intervention for children, to strengthen the mother child relationship and also strengthen the family relationships. Safety planning (n=15; 100%) is clearly a priority not only from a case management perspective but also therapeutically.

Case file information demonstrates that emotional regulation (n = 14; 93%), building communication skills (n=12; 80%), building family relationships (n=11; 73%), engaging with school and learning (n=7, 46%), and education about trauma and impact on children (n=6; 40%) were the most prominent therapeutic activities. It was also noted that there were also activities that enhanced skills such as building routines and how to externalise worries.

Some of the families engaged in specific therapeutic programs or approaches such as the "The Garden" program (an 8 session trauma informed attachment and attunement program for women together with their child who have experienced DFV) (n=3; 20%), and psychoeducational parenting conversations that incorporate both parent and children understanding their "Window of Tolerance" to support emotional regulation, co regulation and relationship building (n=4; 26%).

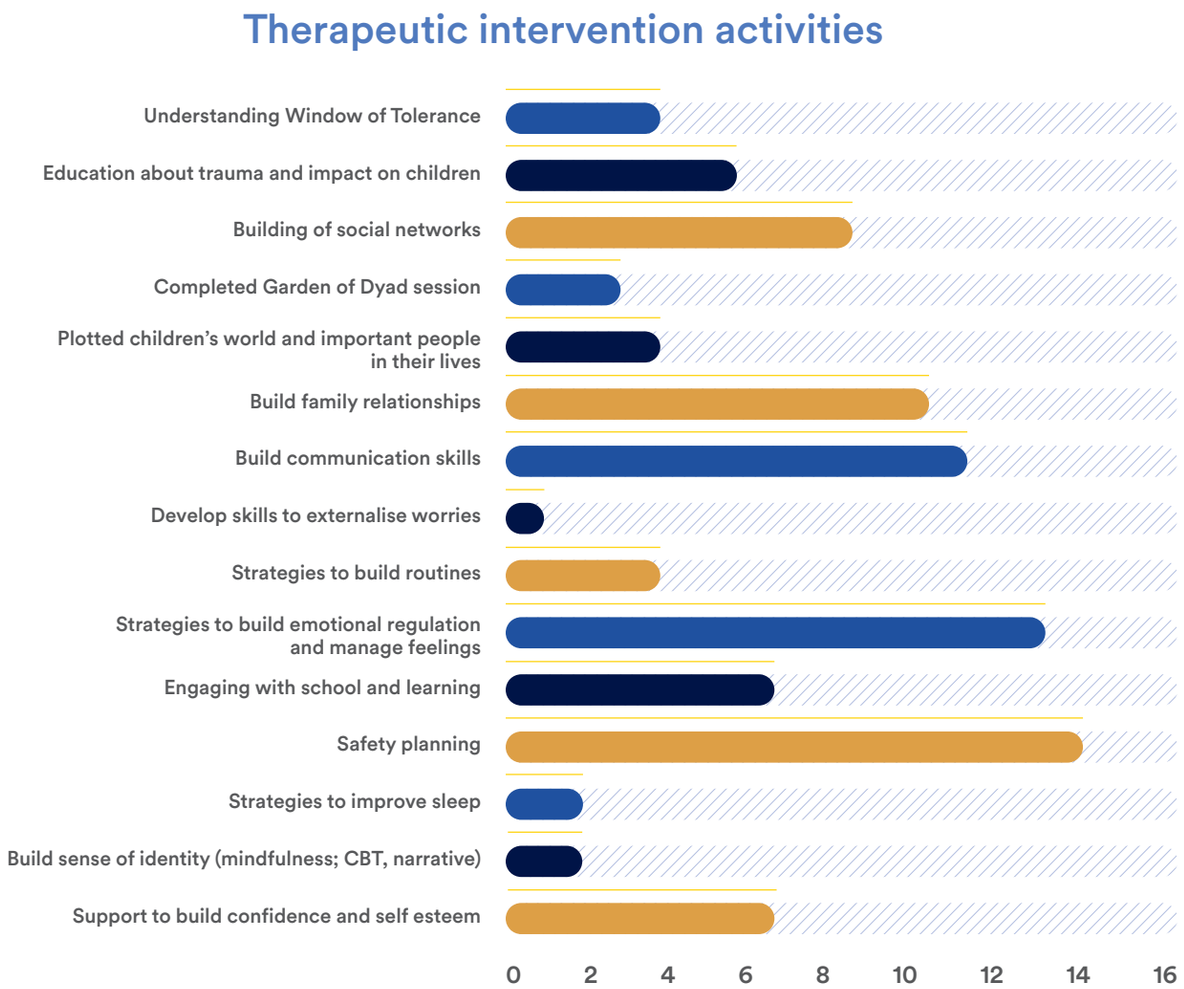


Figure 11 *Therapeutic intervention activities*

Legal services intervention

The other core element of the Program is the provision of legal services. As demonstrated in Figure 12, more than half of the families (n=8, 53%) were provided with legal services. Of the eight families who were provided with legal services, all families (n=8, 100%) were provided advice about children and custody issues, six families (75%) were provided advice about intervention orders or engaging with the police about the violence, and three families (38%) were provided with legal services/advice in relation to assessment of parenting and pre-court actions, advice about parenting and safety, and seeking of recovery orders. Recovery orders are a provision under the Family Law Act 1975 which "can authorise or direct a person or persons, such as police officers, to take appropriate action to find, recover and deliver a child" (Federal Circuit and Family Law Court of Australia, n.d.).

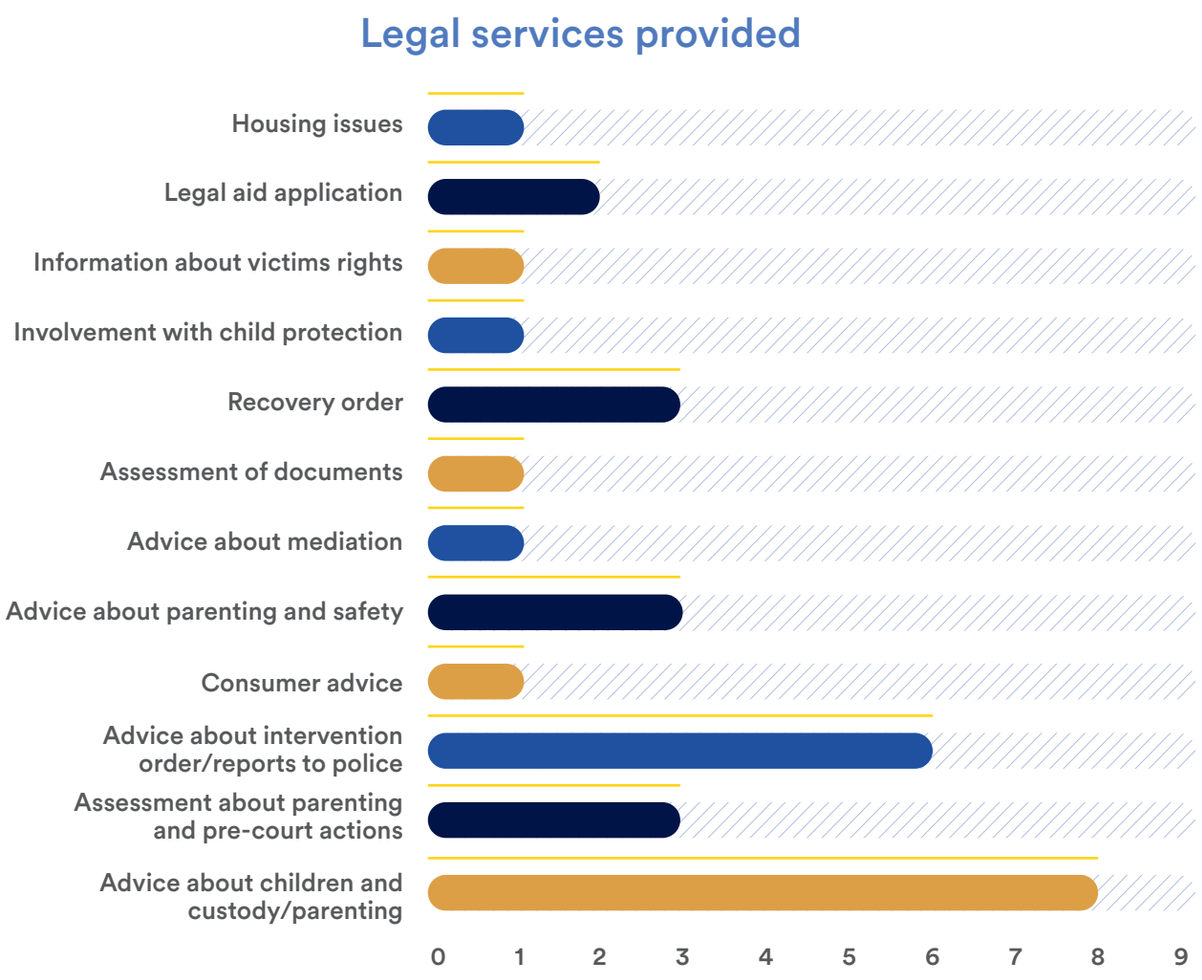


Figure 12 *Legal services provided*

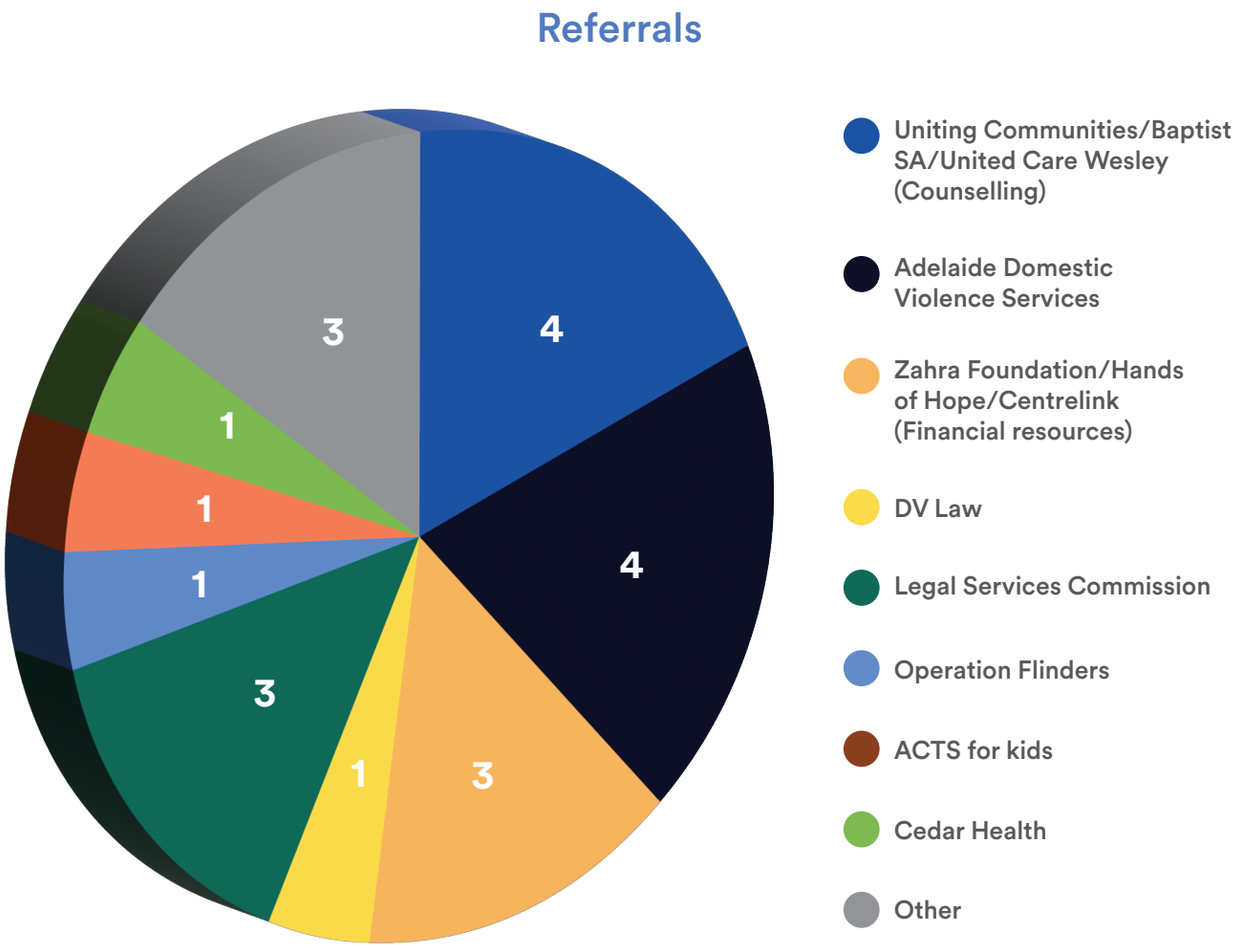


Figure 13 *Referrals to other agencies*

Referrals

Referrals are an important aspect of the Program, given its relatively short but intensive delivery period. Given the impact of trauma on the children and young people, ensuring that children and families are referred to ongoing services is vital. Figure 13 outlines the referrals made. Of the fifteen families, four families (26%) were referred for further counselling and required additional intervention from Adelaide Domestic Violence Services, three families (20%) needed additional financial counselling/financial resources, and in need of further legal services.

Outcomes of Intervention with Safe and Well Kids Program

Traditionally, outcomes are difficult to measure for community service programs. The outcomes reported (see Figure 14) have been informed by the short-term outcomes articulated in the program logic. The findings have been informed by the available information in the case files and via documented feedback from the mothers and children included in the relevant documentation.

The findings demonstrated that mothers and their children were supported to recover and make sense of the experiences of trauma that disrupted their relationships and contributed to parental stress. Qualitative feedback from mothers articulated that they, and their children felt supported by engaging in therapeutic intervention and case management activities. Analysis of information suggests that many of the parents expressed that they felt more confident as a parent; more connected to their children; more attuned to their child's needs; able to engage in discussions regarding the children's feelings, understand their behaviours, and support them to regulate their emotions. In feeling more confident as a parent, they were more able to set boundaries and attend to day-to-day parenting responsibilities. Information documented for one mother exemplified these positive outcomes. The mother felt that the therapeutic worker was walking alongside her and her child on a healing journey. The mother also reported that:

> *"I felt listened to by both workers...I liked being involved in the parenting group and the grow program...I felt like I was supported to have a better relationship with the day care, and they are more aware of my son's needs, and I feel like I have a community with them and feel supported".*

Information extracted from the case files also demonstrated evidence that all twenty-eight children in this study cohort were provided opportunities to make sense of their trauma with positive outcomes. There were improvements in the children's overall wellbeing, emotional literacy and regulation; there was a notable increase in emotional literacy for both the mothers and their children; the children developed skills in recognising their emotions, and developed increased confidence and trust that their mothers would respond to their needs.

Information is suggestive of positive outcomes for the fifteen families receiving practical supports through case management to restore their safety and stability. Alongside the practical supports, the practitioners also provided a range of emotional supports to the children and families which enhanced the therapeutic interventions including strengthening family relationships, engaging in conversations about emotional safety, safety planning for visitations with father, and education and discussions about domestic and family violence.

The families engaged with Legal Services in varying degrees, however there were some families already connected to other services or had already organised legal representation. Most of the families had legal health checks conducted and advice was given across a range of areas which included family law, property settlements, leasing arrangements, advice about intervention orders and safety, complying with pre-court actions, mediation, and retrieval of property. The provision of legal services ensured that child centred legal information, supports and advice was provided enabling women to make informed safety decisions for them and their children.

Of the fifteen families, a third of the families (33%) reported improved cultural connections which is a key deliverable for the Program – '*Aboriginal children and mothers are prioritised and being responded to in ways that support the best interest of the child in family, community and culture*'. Of the fifteen families, almost a third (26%) were identified as Aboriginal families. Each of the families reported positive feedback about the interventions provided through the Program and outcomes achieved. One of the mothers stated that *'she felt listened to and very respected by all involved'* by all three services. Another mother advised that '*she felt that the Program had been a great help to her family and stated that she had felt listened to and that all work done with her, and her children felt safe and culturally respectful*'.

The Program is also committed to providing culturally responsive services – "Services are delivered in ways that are responsive to the cultural context of the family". Of the fifteen families, almost a third (n=4, 26%) were identified as having a culturally and linguistically diverse background.

Feedback provided stated that *"She appreciates the information and therapeutic interventions given to her daughter, and is grateful that she has access to interpreters, where she is able to say her needs and know that she is being understood".*

Identified outcomes

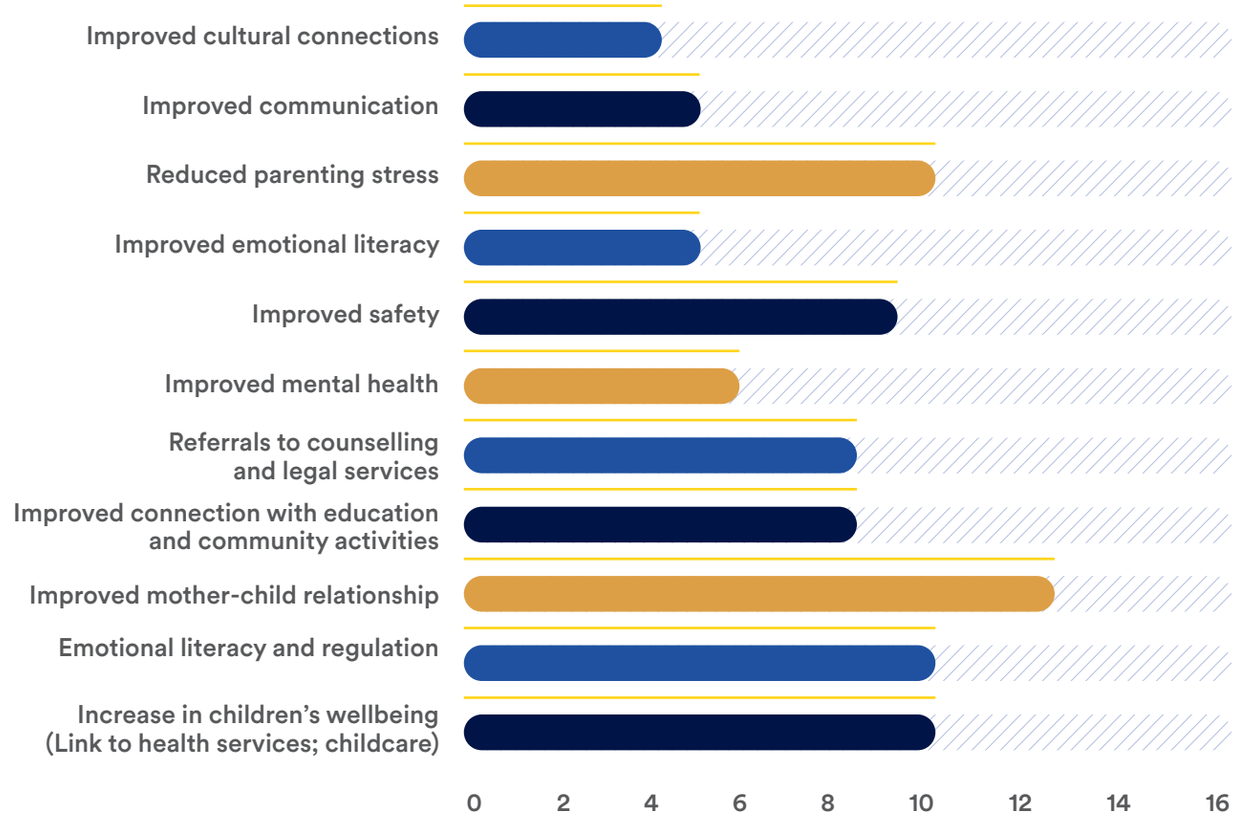


Figure 14 *Identified outcomes*

Discussion

The aim of the review was to identify the characteristics of the families in the Program and to map interventions and identify outcomes for the women and children who engaged in the program. The outcomes expected (based on the short-term outcomes in the program logic) were:

1. Mothers are empowered to make informed decisions (including legal decisions) about their own and their children's immediate wellbeing and physical/emotional safety.
2. Mothers are supported to focus on and notice their children's responses to trauma.
3. Mothers and their children receive the practical support required to restore safety.
4. Children are provided with opportunities to make sense of their experiences, and mother have a strong sense of their rights, and
5. Obligations within a legal framework and make decisions in the best interests of their children.

Consistent with previous studies (Bastian & Wendt 2023) the fifteen families in the review demonstrated characteristics of complexity and trauma resulting from the domestic and family violence. The characteristics and experiences outlined in this report are demonstrative of this complexity and adversity at the intersection of domestic and family violence and child protection. Most of the children experienced emotional abuse, disruption in their schooling, relationships and adverse socioemotional and developmental functioning. Also, two thirds of the families had two or more children, and more than half of the children were eight years or younger, meaning that many of the children experienced domestic and family violence in critical developmentally formative years (Stanley & Humphreys 2017).

The women who sought the services of the Program experienced homelessness, substance abuse, mental health issues and social isolation. Many of the women experienced homelessness and mental health issues that impacted their wellbeing and their ability to provide safe and attuned parenting. Furthermore, a third of the families experienced domestic and family violence perpetrated by more than one person. There was limited information about the men who perpetrated violence. Two thirds of the families were from diverse cultural backgrounds highlighting the need for culturally responsive services for Culturally and Linguistically Diverse and Aboriginal families.

The Program was able to attend to this complexity as an integrated program which facilitated interconnected responses, sharing of information, and ongoing processes to enhance communication and shared decision making. Some families needed more immediate material and external/community supports (child-care, health, school etc), while others required greater levels of therapeutic supports. Whilst always prioritizing safety, it is clear from the case studies that the children and family's immediate material needs were addressed, and case managers and therapeutic interventions were adapted to meet the children's diverse and unique needs, regardless of the family composition and complexity.

Recent studies (Bastian & Wendt 2023; Bastian et al 2023) highlight the lack of child centred services for children and young people who experience domestic and family violence. The Program addresses this gap. The program is grounded in the belief that children and young people are victim/survivors in their own right and have unique needs, and those needs inform the case management, therapeutic, and legal responses. Intervention from the program ranges from crisis intervention right through to therapeutic intervention contributing to the disruption of the impacts of violence and offers the opportunity to engage in healing and recovery and strengthening of relationships. The provision of services to children and their mothers also contributes to improved understanding of domestic and family violence within the family system and enhances safety and stability for the entire family.

Working within an integrated service model enhances professional networks and professional development opportunities. The Safe and Well Kids program integrates three very different services, and in bringing these services together increases service sector and worker capacity to provide safety, conduct comprehensive risk assessments, and design flexible and responsive services are holistic that are trauma and domestic violence informed. The program also provided a unique opportunity for the mothers and children, especially those in shelters and crisis accommodation to access external services and have interactions with workers to ensure their needs were met. Research suggests that residing in shelters presents women and children many advantages beyond immediate safety which include supporting longer term housing stability; provision of support for emotional and physical wellbeing; participation in education; and access to other resources (Chanmugam,2015).

Types of interventions provided by shelters can include crisis support, counselling advice, links to support networks and training, job placement, and referrals to other services (Wathen et al., 2015; Øverlien, 2011). The workforce in shelters is also well placed through their daily interactions with children to assess their needs, ensure that their immediate needs are met, implement targeted interventions, and develop longer-term service support strategies.

There is substantial evidence from the case files that a child-focussed approach has informed the breadth and depth of services offered across the three domains of the program including crisis intervention, practical support, case management, therapeutic intervention and legal support services. The data demonstrates wide ranging interventions, activities and supports including referrals during and after the case had closed for the families. This is important to recognise given the short delivery period in which each family was engaged with the Program (although some had slightly longer). It was clear from the data that each child and family's unique circumstances were considered, and that the case conferencing was overall effective to ensure consistent, co-ordinated, and complimentary intervention.

An important outcome required by the program logic was to have evidence of improved mother and child relationship and for mothers to be supported to focus and notice their children's trauma. Having both therapeutic intervention and case management concurrently as part of the service delivery was beneficial for the improvement of mother-child relationships a majority of the families reporting improvement in areas of parenting; mothers feeling more connected and confident in parenting their children; and gaining new skills to support their children regulate their emotions. This is a significant outcome for the program considering the short time frame for delivery and aligns with other research around the benefits of child-parent relationships being important for recovery (Hooker, L.et al. (2022).

Across the case studies, there were varying levels of engagement with all three services, in part due to the presenting capacity of the families and their individual and economic circumstances, cultural background, perpetrator interactions and existing social supports. In some cases, all three services were accessed, whereas with others, only parts of the program were accessed. For example, some of the families had already engaged other legal services or it was not necessary, or families engaged with therapeutic interventions more than case management and vice versa. Overall, it seems evident from the qualitative feedback from mothers that having all three services on offer, and able to adapt to the needs of the children and families at the start of the engagement was beneficial and comforting.

The Safe and Well Kids Program supported domestic and family violence case managers in their work with mothers, which they indicated was due to the children having their material and emotional needs met and helping reduce overall stress. The integrated program provided opportunities for the mother to become more empowered to make informed decisions about the children's wellbeing and safety, understand legal requirements and supporting mothers to make sense of their children's trauma and enhance their parenting capacity.

Conclusion: Implications for Practice

The review of the Safe and Well Kids Program was conducted at a time where the program was continuing to evolve and move towards increasing integration. There has been substantial investment and effort into moving from three distinct service providers towards a model where children and young people who experience domestic and family violence are provided services (with their mothers) that are integrated and encompass crisis intervention, case management, practical support, therapeutic intervention, and legal services. It should be noted that the data collected for this review may not now reflect the current integrated program, however has provided a preliminary view of its effectiveness in working with children and young people who have experienced domestic and family violence..

The intention of the updated program has been met with evidence that "the safety, stability and recovery of women and children impacted by domestic violence is secured through access to holistic and co-ordinated service" (Safe and Well Kids 2023). The benefits of an integrated program are evident, particularly in relation to the Program's flexibility and adaptability within a short delivery period. The child focused nature of the Program is also clearly evident in the case files, supported by the ongoing case meetings/ conferences/huddle meetings across the delivery period which aligns with good practice for an integrated, wrap around service.

Integration could be further enhanced by the services increasing co-ordination and sharing of information, implementation of documents fit for purpose for the program, improved data collection, clarity about roles, responsibilities and intervention time frames, and data collected which has more inclusion of the voices and lived experiences of women and children.

Overwhelmingly integrated responses to domestic and family violence are perceived as a useful and progressive approach to supporting victim/survivor safety, perpetrator accountability and promoting perpetrator visibility with respect to promoting risk management and information sharing strategies. Integrated initiatives are used to support inclusive and different parts of the service and support systems responding to domestic and family violence and victim/ survivor safety and recovery needs (Wilcox 2010).

Recommendations

1. That this program continues, and continued funding is provided to ensure that children and their mothers who experience domestic and family violence are provided case management, therapeutic intervention, and access to legal services.
2. That the funding be flexible and responsive to the individual and unique needs of children rather than restricted to a specified twelve-week program.
3. That systems be established so as to track the progress of children and their families to determine whether medium- and long-term outcomes are achieved.
4. The Program continue to enhance integration by establishing sustainable approaches for information sharing, shared decision making, and clarity about roles and responsibilities.
5. That the Program explore the option of including a culturally appropriate and safe family based response.
6. That additional research funding be provided so that the voices of children and their families be interviewed so in-depth qualitative information be included in an evaluation.

References

Karlsson, Jan Ch, and Stephen Ackroyd. “Critical Realism, Research Techniques, and Research Designs.” (2014): 21-45.

Bastian, Carmela, and Sarah Wendt. “Collaboration between child protection and domestic and family violence: A case file review.” Australian Social Work 76.2 (2023): 186-202.

Bastian et al 2023 Improving Service Responses for Children and Young People Who Experience Domestic and Family Violence: A Way Forward, Australian Social Work, DOI: 10.1080/0312407X.2023.2267046

Campo, M. (2015). Children’s exposure to domestic and family violence – Key issues and response (CFCA Paper No. 36,

Issue. A. I. o. F. Studies. https://aifs.gov.au/cfca/publications/childrens-exposure-domesticand-family-violence

Chambon, Adrienne S. Reading Foucault for social work. Columbia University Press, 1999.

Chanugam, A. (2015). Children and young people in domestic and family violence shelters. In C.

Freeman, P. Tranter, & T. Skelton (Eds.), Risk, protection, provision and policy. Geographies of children and young people (Vol. 12; pp. 19–44). Springer.

Connolly, M., Humphreys, C., & Healey, L. (2017). The Collaborative Practice Framework for Child

Protection and Specialist Domestic and Family Violence Services: The PATRICIA Project: Key Findings and Future Directions.

Howe 2010 The Safety of Children and the Parent-Worker Relationship in Cases of Child Abuse and Neglect, Child Abuse Review 19 (5):

Hooker, Leesa, et al. RECOVER–Reconnecting mothers and children after family violence: The child–parent psychotherapy pilot. Australia’s National Research Organisation for Women’s Safety, 2022.

Øverlien, C. (2011). Women’s refuges as intervention arenas for children who experience domestic violence. Child Care in Practice, 17(4), 375–391. https://doi.org/10.1080/13575279.2011.596816

Powell, Anastasia, and Suellen Murray. “Children and domestic violence: Constructing a policy problem in Australia and New Zealand.” Social & Legal Studies 17.4 (2008): 453-473.

The National Plan to End Violence Against Women and Children 2022–2032

Wodak, Ruth, Michael Meyer, and Stefan Titscher. “Methods of text and discourse analysis: In search of meaning.” Methods of Text and Discourse Analysis (2000): 1-288.

Stanley, Nicky, and Cathy Humphreys. “Identifying the key components of a ‘whole family’intervention for families experiencing domestic violence and abuse.” Journal of gender-based violence 1.1 (2017): 99-115.

Stanley, Nicky, and Jill Manthorpe, eds. The age of inquiry: Learning and blaming in health and social care. Psychology Press, 2004.

Wilcox, Rand R. Fundamentals of modern statistical methods: Substantially improving power and accuracy. Vol. 249. New York: Springer, 2010.

Yin, Robert K. “Case study methods.” (2012).

Appendix A: Family vignettes

Family One

The mother and the children were provided case management services, therapeutic intervention, practical supports, and legal services/advice. This family had significant positive outcomes across all the domains of the program. There were significant increases in the children's overall wellbeing, emotional literacy and regulation and the mother was better able to understand and respond to her children's needs. The family was connected to education, community activities and were referred to on-going counselling and legal services. Connection to education was significant, particularly for the oldest child who presented with suicidal ideation at the commencement of the program. The family benefited from having two Program referrals and the collaboration between the services supported joint home-visits which further supported the children's emotional wellbeing.

Family two

The mother identified that the work with the Safe and Well Kids Program was 'slow going' in the beginning, but that then engaged intensively with the program. She said that working with three services helped her to understand the needs of her children better. She felt listened to and very respected by all involved.
The mother reported that the legal services were very helpful and were available to answer all questions and the therapeutic intervention strengthened her relationships with her children and more confident in her parenting abilities. The mother found the case management services very helpful in providing appropriate referrals for her children. The mother also provided feedback that she would have like the program to go for a longer period.

Family three

This family with three children accessed case-management services and some therapeutic supports but did not engage with legal services. The children's therapeutic goals were achieved over the time of the intervention as they displayed a clearer understanding of their emotions and their triggers. The children were also able to understand grounding techniques to manage their emotions. This family was supported with regular meetings; finding and accessing community and recreation activities; linking with school cultural support; abuilding independence, and goal setting.

Family four

The mother and her three-year-old child was referred to Safe and Well Kids Program. There were two other children in this family however they did not engage with the service. The mother and child were provided case management services, therapeutic intervention, and legal advice. There was reported improvement in mother noticing her child's emotional state and responding to her needs, and child also has become more aware of others' emotions. The mother noticed differences in her interactions with child and stated that before they didn't have a rich connection time together but now, she understands the importance of delighting in things child does and actively participates in these activities. Mother is settling more easily, and she feels more confident in her parenting. Worker stated that child is interacting with adults with whom she feels safe and is laughing and talking more. The mother advised that she felt very supported and heard by the workers in the Program. She appreciates the information provided to her and opportunity to engage in therapeutic intervention as it has strengthened her and relationships with her children. The use of interpreters enabled her to have her say, express her needs, and ensure that she was understood.

Family five

At the time of referral the family was living in crisis accommodation. The family were provided services through case management, engaged in therapeutic intervention, and provided legal services. Interpreter used at the start of the intervention. All therapeutic goals were achieved for the children which included building rapport, positive communication, understanding bodily responses, emotional stability, and mindfulness. Children were able to voice their needs more confidently by the end of sessions. There was some need to explore further support for the mother around in relation to attachment styles and family roles. The mother initially participated in general conversation focusing on the relevant issues however she chose not to engage in an in-depth way and disengaged.

Family six

The mother and her two children engaged in therapeutic intervention. The mother reported being able to understand her children better and hold space to co-regulate; improved understanding of the impact of trauma, noticing behaviour being communication, and

increasing her ability to interpret cues and understanding of circle of security. The worker noted that the mother attachment was strengthened and improved child-parent relationship. The older child built up confidence within the therapeutic work to recognise what elements within her life needed changing and was able to identify and articulate this to her parent. She reported an increase in her confidence where she noted thoughts which impacted both her behaviours and feelings and recognised what elements within her life needed changing.

Family seven

The mother had not cared for her two children for twelve months and needed to support to reconnect with them, re-establish her parenting to manage their behaviours and ensure the children re-engaged with school. The family was provided services through case management, they engaged in therapeutic intervention, were provided legal services. Mother advised that the Program had been a great help for her family and that she was listened to, and she and her children felt safe, and culturally respected. She felt that the practitioners were responsive in providing her with information and safety concerns were addressed quickly. Mother also advised that communication with her children had improved significantly, and both children were able to identify their feelings and have conversations with their mother which had been missing. The children were talking more with other adults in their lives, particularly at school where they engaged with a school counsellor. With support the family was able to establish a routine improving family dynamics and relationships. The mother also stated that she liked having all three services involved as she was able to manage issues in a holistic way and was grateful that the workers could travel to her to attend appointments. Mother also felt that twelve weeks was just the right amount of time for her, and the girls and she could engage and gain new tools which she feels will support her parenting into the future.

Family eight

The integrated program was flexible and responsive to the needs of the two children in this family. Initially practitioners worked with the mother and younger child then made alternative arrangements as the older child went to live with the father (not the perpetrator). The program was modified and extended the therapeutic period to continue supporting the family. Outcomes for the children included: increased understanding about safe and unsafe, ability to demonstrate day-to-day skills, and they developed skills regarding recognition of overwhelming emotions and regulate when needed. The mother reported that her older child developed skills regarding recognition of overwhelming emotions and ability to ground when needed. The workers and mother both reported that the older boy came a long way and could concentrate and manage his emotions. The mother stated that the children enjoyed the sessions with Relationships Australia very much and has noticed that the children are flourishing. As a parent, she feels confident to parent her children and connect with the children better; is bonding well with them; able to set boundaries; understand their behaviours and feelings and respond appropriately to their needs. She now has several new tools to be able to implement at home.

Family nine

The mother engaged in all services provided and reported being supported to have a better relationship with childcare services and more aware of her son's needs. The mother engaged in the Garden of Dyad program that enhanced parent-child attunement; parent observation; and learning co-regulation strategies. The mother reported increased understanding of her child's emotional needs, his behaviours/way of communicating them and how to meet them, and that she could help her child calm down more effectively. The mother reported that the child was more settled at childcare and at home. The mother felt safe and listened to by Safe and Well Kids workers and was workers and satisfied with service. Her child's needs were met, and the mother was managing better because of the program. The worker reported there was greater understanding of the impact of domestic and family violence on children and she was happy with referrals made by case manager.

Family ten

The family with a young child engaged in all aspects of Safe and Well Kids interventions including case management, therapeutic intervention, and engaged with legal services. The family was connected to a range of services including health, education (child-care); Centrelink for financial services, and safety planning. The mother gave feedback that she understood her

child's behaviour better and she was able to meet her child's emotional needs and co regulate. Mother was able to facilitate discussions regarding her child's feelings and the worker and mother discussed ways to support child further. There was notable increased emotional literacy for both child and mother. Activities provided space for increased connection and co regulation including routine board for each session. Mother stated that she was very happy with the support that she had received from Safe and Well Kids, and her child had enjoyed the calm down box from the children's case manager and had a few tools that she can use the window of tolerance. (A two-week extension was granted to complete application and orientation at childcare).

Family eleven

The mother and her young child accessed case management services, engaged in therapeutic intervention, and provided advice from legal services. As a result of Safe and Well Kids therapeutic intervention the mother-child relationship was strengthened and focused on emotional safety and co-regulation. Mother and child attended Together for Kids group with positive feedback and will continue to attend. The case manager also worked closely with the child using arts-based activities. The mother worked closely with the case manager focusing on improving her parenting skills and decision making about her and her child's life.

Family twelve

The family made up of the mother and young child was assessed as being relatively stable and only requiring therapeutic and legal services. The mother reported increase in communication with her child, an increased emotional vocabulary and more attuned to her child's needs, and able to establish boundaries with less emotional upset from the child. The therapeutic worker observed a positive change in the mother's ability to attune to her child's emotional needs and to co-regulate with her child. Case worker also noted that mother was trying her best and was responsive to her child's needs implementing strategies that she had learned. Despite the increase in perpetrator activity, the mother and child remained engaged with therapeutic work and the mother reported that she was very grateful for the opportunity to engage in therapeutic intervention.

Family thirteen

This mother and two children only accessed intensive case management services for an extended period demonstrating that the program was responsive to the needs of the family at time of referral. The impact of having intensive case management enabled the the children and the mother to engage with the service ensuring that the family was safe and stable. The practical supports for the children and mother provided space for the mother to engage with domestic violence counselling and adhere to safety planning. The mother was also able to engage with medical professionals and a counsellor to improve the relationships with her children. By having the practical supports in place, the mother was able to discuss her needs in relation to financial support and meet Housing SA mutual obligations, leading to securing a transitional house in Thebarton. The mother spoke very positively about the Safe and Well Kids case management and support received. The eldest child re-engaged with school and the family were referred to several services to ensure that they were provided with ongoing legal, financial and family support as required. This families situation demonstrates the impact for the family when intensive work is offered, and the client is ready and able to engage thereby setting them up for their longer-term success. The engagement and referrals across education, health, community organisations were also important.

Family fourteen

The mother and teenager were reported to be involved with program for longer than twelve weeks however there was limited engagement with intervention. The family were provided services through case management, only engaged in three therapeutic sessions due to cancellations by family or worker ill health and did not engage with legal services. Despite limited engagement there were still some positive outcomes noted. The child learned about circle of control and developed understanding of domestic and family violence, reflecting on her history with father and that her relationships with friends making changes to the kinds of relationships she would like. The child reflected on the service and talked about learning about how she can only control what she does. Due to the limited engagement with the program, referrals were made to other services.

Family fifteen

The mother and two children lived in transitional housing and had difficulty engaging with the program due to the mother's ill health. The children returned to live with their father. The children were enrolled into a different school and the mother also lost her driver's licence. The added stress of the children being with the father who perpetrated violence exacerbated the mother's mental health issues. The mother was provided with case management services, some therapeutic intervention

however no involvement with legal services. The goals for the children were only partially met. The mother was supported to grow her understanding of children's needs and behaviours through psychoeducation on trauma and responses, co-regulation. The mother reported an increase in her children seeking emotional support from her, sharing their worries and feelings verbally rather than withholding. Children reconnected to school and friends by the end of program which had a positive impact on family emotional wellbeing. The mother reported an increase in support for own mental health which increased her capacity to be emotionally available for her children, allowing her to have her children return home for full time care by the end of program.

There was ongoing collaborative case management and the development of positive client centred working relationships through information sharing between service workers and child assessments. Conversations with mum in relation to child wellbeing safety risk and needs and safety plans were attempted for the children when with their father. The The Safe and Well Kids team were able to make some improvements to mother's ability to engage with her children and understand the impacts of the trauma.

Appendix B: Data collection instruments

Children and their journey: Safe and Well Kids

Record ID	_____
Date of referral	_____
Cultural background (child/ren)	☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal ☐ CALD ☐ Other
Cultural background (woman)	☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal ☐ CALD ☐ Other
Cultural background (man 1)	☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal ☐ CALD ☐ Other
Cultural background (man 2) (if applicable)	☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Aboriginal ☐ CALD ☐ Other ☐ N/A
Please add an additional comments about culture if necessary	_____ (This might be useful if you have a family where the woman and man have different cultural backgrounds or there is diversity among the child/ren dependent on paternity)
Is English a second language?	◯ Yes ◯ No ◯ Unsure

1. Family relationships

Placing the child/ren central to our analysis, what is the relationship of the child/ren to the woman?	◯ Mother ◯ Step-mother ◯ Grandmother ◯ Aunty ◯ Kinship carer ◯ Foster carers ◯ Sibling ◯ Other (Identifying relationships)
What is the relationship of the child/ren to the man?	☐ Father ☐ Mother's partner ☐ Mother's ex-partner ☐ Other ☐ Unknown
Are there other important relationships identified for child/ren?	_____ (Document if there are other relationships identified for the child/ren.)

2. Previous service provision and intervention (legal, housing, safety, therapy)

Is there information available that indicates child/ren were in receipt of services prior to involvement with S&WK?	◯ Yes ◯ No ◯ No information available (This is to try and identify if children and family were involved with services prior to SWK intervention)
If child/ren was/were recipient/s of other services, please identify the agencies involved/ which services the child/ren received.	_____
If child/ren involved with services prior to SW&K intervention summarise information available.	_____ (Summarise any information including type of intervention and outcomes of intervention provided. If no information available record "no information")
Is there any information available that indicates the woman was a recipient of services prior to involvement with S&WK?	◯ Yes ◯ No ◯ No information available
If the woman was a recipient of other services, please identify the agencies with which they were involved.	_____
Is there information available that indicates the man was provided services prior to involvement with S&WK?	◯ Yes ◯ No ◯ No information available
If the man was a recipient of other services, please identify the agencies involved.	_____

3. Information about children when referred to Safe and Well Kids

What was the assessed level of risk for this family at the beginning of intervention?

_____
(Please use the Family Safety Framework assessment form. Record the risk level and what this means)

Was there an assessment about the impact of the man's behaviour on the child/ren?

◯ Yes
◯ No
◯ Unsure

Please provide a description of the impact of violence on the child/ren?

_____
(Usually you can find some comments in the FSF document.)

Number of child/ren residing with the woman at initial engagement with S&WK

_____
(Important to identify how many children were part of the referral process and living with the mother)

Ages of the child/ren of the families referred to S&WK?

☐ Unborn
☐ 0-12 months
☐ 1-2 years
☐ 3-4 years
☐ 5-8 years
☐ 9-12 years
☐ 13-14 years
☐ 15-18 years
☐ 18 years +
☐ Unsure

What were the child/ren's experiences of trauma?

☐ Emotional abuse
☐ Physical abuse
☐ Emotional neglect
☐ Physical neglect
☐ Supervisory neglect
☐ Sexual abuse
☐ Removal from parental care
☐ Other

What were the documented issues recorded for the child/ren?	☐ Homelessness ☐ Isolation ☐ Behaviour issues (withdrawn; aggressiveness; fearful) ☐ Global developmental delay ☐ Physical disability ☐ School issues (non-attendance; poor performance; learning difficulties) ☐ Mental/emotional distress (i.e. bedwetting; soiling) ☐ Sleeping difficulties ☐ Eating disruptions ☐ Poor eye contact and avoidance ☐ Highly anxious ☐ Difficulty to be soothed ☐ Sexualised behaviour ☐ Inability to settle or concentrate ☐ Separation from mother and/or father ☐ Disrupted relationships ☐ Loss of cultural connection ☐ Other (This is about impact of the child/ren's experiences using a trauma informed approach)
Provide further details about the children's identified issues and experiences of trauma.	_____ (This section enables the documenting of more information about the children's experiences of trauma)
What were the identified developmental concerns for the child/ren recorded at the time of referral? If no, state N/A	_____ (Record specific identified issues about any developmental concerns)
What were the identified health concerns for the child/ren recorded at the time of referral? If no, state N/A	_____
What were the identified education needs of the child/ren at the time of referral? If no, state N/A	_____

4. Information about the woman

What were the assessed issues experienced by the woman?

- ☐ Domestic and family violence
- ☐ Mental health/mental distress
- ☐ Drug and alcohol
- ☐ Childhood trauma
- ☐ Child protection history
- ☐ Homelessness
- ☐ Criminal activity
- ☐ Parental stress
- ☐ Physical disability
- ☐ Intellectual disability
- ☐ Acquired brain injury
- ☐ Financial issues
- ☐ Intervention orders
- ☐ Youth court matters
- ☐ Family court matters
- ☐ Current legal matters
- ☐ Health issues
- ☐ Other

(This is about identifying the factors impacting on the mother)

Please provide additional information on the identified issues experienced by the woman

_____

5. Information about the man/perpetrator?

Was the pattern of behaviour perpetrated by the man documented?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please provide details about the male's pattern of violent behaviours?

_____

(This information is available in the Family Safety Framework assessment framework)

Were there orders that applied to the perpetrator?

- ◯ Yes
- ◯ No
- ◯ Unsure

Please describe any legal orders that apply to the perpetrator.	_____
What were the identified issues identified by the man?	☐ Domestic and family violence (Perpetrator) ☐ Mental health/mental distress ☐ Drug and alcohol ☐ Childhood trauma ☐ Child protection history ☐ Homelessness ☐ Criminal activity ☐ Parental stress ☐ Physical disability ☐ Intellectual disability ☐ Acquired brain injury ☐ Financial issues ☐ Intervention orders ☐ Youth court matters ☐ Family court matters ☐ Current legal matters ☐ Other ☐ N/A
Please provide additional information about issues experienced by the man (if required)	_____
Has there been a history of more than one perpetrator for the woman and child/ren?	◯ Yes ◯ No ◯ Unsure

6, Other information about family relationships

Are there child/ren who are part of this family but not residing with the mother?	◯ Yes ◯ No ◯ No information (This is to get a sense of the family relationships and previous intervention. If no please skip questions in this section and move to the next section.)
If yes to other child/ren, how many child/ren/young people?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8+
Ages of child/ren who are part of the family but not in the care of the woman?	☐ 0-12 months ☐ 1-3 years ☐ 4-5 years ☐ 5-8 years ☐ 9-12 years ☐ 13-14 years ☐ 15-18 years ☐ 18+ years ☐ Unknown

If child/ren are not residing with the woman, where are they residing?	☐ With their father ☐ With grandparents ☐ With extended or kinship family ☐ Family based foster care ☐ Residential care ☐ Other ☐ Unknown
Is the man a current or historical perpetrator?	◯ Current ◯ Historical ◯ Unknown

7. Intervention and outcomes for children

Provide details of case plan and identified goals for the child/ren.	_____ (These goals can be identified through WSSSA children's case manager, Huddle documents, and RASA case files. Consider issues of housing, therapeutic intervention, connected to important people in their lives)
To achieve safety and wellbeing of the child/ren, what specific interventions were actioned by WSSSA?	_____ (Describe what interventions were put in place with the children to achieve their safety and wellbeing)
To achieve safety and wellbeing of the child/ren, what specific interventions were actioned by RASA?	_____ (Describe what interventions were put in place with the children to achieve their safety and wellbeing)
Were the goals for child/ren achieved?	◯ Yes ◯ No ◯ Unsure
If outcomes achieved, describe how the outcomes were achieved?	_____ (Consider indicators for child's safety - connection to others; therapeutic intervention; ability to participate in intervention (heard and seen); settled and attending school; stable housing;)
If outcomes not achieved please describe why?	_____
Over what timeframe did the interventions occur?	_____

Were child/ren who initially resided with the woman placed in alternative living circumstances during the period of intervention with S&WK?	◯ Yes ◯ No ◯ Not applicable (This is to determine whether child/ren, who resided with mum at initial intervention with WSSSA, were placed in care or went to live with the man or elsewhere during the period of intervention with S&WK?)
If children placed in alternative living circumstances during intervention with S&WK, describe the circumstances.	_____ (If no, state N/A. If yes, describe specific details, including the circumstances that contributed to the child/ren being placed in the alternative living situation.)

8. Intervention and outcomes for woman

Provide details of the case plan and specific goals for the woman?	_____ (Summarise the goals outlined in the case plan for the woman to achieve her safety and wellbeing.)
To achieve safety and wellbeing of the woman, what specific interventions were actioned by WSSSA?	_____ (Describe what interventions were put in place with the woman to achieve their safety and wellbeing. Consider the level of the woman's engagement with services, psychosocial education, links to access other practice supports.)
To achieve safety and wellbeing of the woman, what specific interventions were actioned by RASA?	_____ (Describe what interventions were put in place with the woman to achieve their safety and wellbeing. Intervention by RASA may be more focused on the building connections with the child)
To achieve safety and wellbeing of the woman, what specific interventions were actioned by Legal Services Commission?	_____ (Describe what interventions were put in place with the woman to achieve their safety and wellbeing)
Were the goals for woman achieved?	◯ Yes ◯ No ◯ Unsure

If outcomes achieved, describe how the outcomes were achieved?	_____ (Consider indicators for the woman's safety - financial stability; housing; visibility of perpetrator; legal orders; able to make decisions about herself and child/ren; engaging in therapy; engaged with services)
Was the mother - child relationship strengthened?	◯ Yes ◯ No ◯ Unsure (Consider intervention by WSSSA and RASA that specifically focused on strengthening child - mother relationship)
If the mother-child/ren relationship was strengthened, please provide further information	_____
Please describe if the mother was empowered to make informed decision about their safety and the safety and wellbeing of their children?	_____ (Consider whether the mother was engaged with services, they participated in actioning legal orders, they sought practical assistance, and engaged in therapeutic intervention.)
Over what timeframe did the interventions occur?	_____

9. Cultural safety

If this was family was Aboriginal, was there involvement with extended family/kinship as a protective strategy?	◯ Yes ◯ No ◯ Unclear ◯ Not applicable (If this family not Aboriginal or CALD tick "Not applicable" for each question in this section)
Were there discussion about cultural connections?	◯ Yes ◯ No ◯ Unsure ◯ Not applicable
Please add any other comments relating to cultural safety.	_____ (Connection to kinship and linked to Aboriginal services support cultural connections and strength.)

10. Service integration and collaboration

What process were identified that demonstrated integration/collaboration across the services?

- ☐ Sharing of information by all agencies
- ☐ Shared assessments
- ☐ Shared decision making
- ☐ Shared case plans
- ☐ Coordinated case management
- ☐ Case conferences
- ☐ Other

(These are examples of integrated and collaborative practice)

Describe the evidence that support the answer to the previous question

_____

(This is an opportunity to include more indepth information about what was observed as evidence of integrated practice)

What were the specified roles and responsibilities of each agency?

_____

Please describe how the child/ren were kept in focus in the context of integrated practice?

_____

Provide details of the integrated case plan and identified goals for the woman.

_____

11. Termination of intervention with Safe and Well Kids

During intervention or at the termination of intervention with Safe and Well Kids, was the mother and/or the child referred to other agencies ? If so, please identify which agencies.

- ☐ MAPS
- ☐ Family Safety Framework
- ☐ Multi-Agency Assessment Unit
- ☐ Health
- ☐ Police other than MAPS
- ☐ Department of Corrections
- ☐ Relationships Australia SA
- ☐ Department of Housing
- ☐ CAMHS
- ☐ Mental Health Services
- ☐ Drug and Alcohol Services
- ☐ DCP
- ☐ KWY
- ☐ WSSSA
- ☐ Centacare
- ☐ Anglicare
- ☐ Together 4 Kids
- ☐ Education
- ☐ NGO's (please specify)
- ☐ Child Wellbeing Practitioners
- ☐ Kangarendi (DCP)
- ☐ KWY
- ☐ Other services
- ☐ Not applicable

(Identify if the families were referred to other agencies beyond Safe and Well Kids)

SOCIALLY™
INCLUSIVE
DESIGN

blendcreative.com.au

Flinders University | Social Work Innovation Research Living Space

Appendix 6

Children's Practice Framework

Cover Page

Acknowledgements

WSSSA
Yarredi
Channel 7
Flinders University

Contents Page

Contents

Acknowledgements

We acknowledge that the land that we work on is the traditional lands of the Aboriginal and Torres Strait Islander people and we pay our respects to Elders past, present and emerging. Aboriginal people have made, and continue to make, a unique and irreplaceable contribution to the state of South Australia.

We acknowledge and respect that Aboriginal and Torres Strait Islander people are the First Nations people of this country and recognises Aboriginal people as traditional owners and occupants of South Australian land and waters. We acknowledge that the First Nations people have never ceded sovereignty and remain strong in their enduring connection to land and culture.
We acknowledge that the spiritual, social, cultural, and economic practices of Aboriginal and Torres Strait Islander people come from their traditional lands and waters, and that Aboriginal and Torres Strait Islander people maintain cultural and heritage beliefs, languages and laws that are of ongoing importance today.

We thank the stakeholders involved in this project who contributed valuable time, resources, practice wisdom to this practice framework. Women's Safety Services SA, Yarredi Services (Port Lincoln) and the governance group. Channel 7 research grant for the funding for this work.

In writing this document is important to acknowledge the strength, courage, wisdom, and resilience of the women, children and young people who have lived and continue to live in a context of domestic and family violence. The voices of the women, children and young people who have dedicated their time to enable this document attests to their resourcefulness, capacity, and drive for a better life despite the worst situations that they have experienced.

Children and Young People's Practice Framework

This practice framework has been developed to meet a growing demand to ensure that children are recognised as clients in their own right in the context of domestic and family violence service provision. This practice framework is focused on service provision for children and young people on the domestic and family violence shelters in South Australia however is applicable in other jurisdictions.

This framework has been developed from practice research conducted with practitioners, children, young people, and their families. The learnings that have emanated from conversations with practitioners, children, young people, and their families has been further informed by relevant and contemporary research in this field of practice. This practice framework exemplifies that importance of well-established foundational definitions and understandings, reinforces research and practice knowledge relating to good practice with children, trauma informed practice, and child development. The authors acknowledge that shared understandings and research can change over time as knowledge and understanding grows.

This practice framework acknowledges the complex nature of working with victims/survivors of domestic and family violence, which includes the varying immediate material, physical, emotional, psychological, and cultural safety needs of the children and family upon entry to a service. This framework does not assume that the steps to recovery will be linear but offers a guide to working with children and young people that is child centred demonstrating best practice. Each service will have unique contextual nuances and variations in access to resources, however the values, knowledge and skills required are relevant in all domestic and family violence shelters.

This framework recognises the varying strengths and resilience of the children, young people and their families and communities and the broader social context in which they live. Experiences of domestic and family violence occurs across in all spheres if society irrespective of culture, age, and socio-economic status. It is well known that experiences of domestic and family violence may be influenced by additional and cumulative impact poverty and/or issues of drug and alcohol use; criminality; long term unemployment or precarious employment; mental health issues; intergenerational trauma as a result of colonisation and systemic racism, immigration, or disability issues.

Most importantly, this practice framework is designed to elevate the visibility and voices of children and young people who have experienced trauma and seek safety and refuge within a human service system. Drawing from the children and young peoples lived experience this practice framework has the ability to ensure that children and young people immediate and longer-term needs are met and they are at the centre of all responses going forward.

Children and Young People important in their own right

The experiences of children and young people who live in a context of domestic and family violence has gained increasing importance. Exposure to domestic and family is a recognised form of child abuse in many western nations including Australia, and is reflected in child protection practice guidelines and legislation[1]

Domestic and family violence is a significant issue in Australia with 31.1% of women who had experienced violence by their current partner, and 47.6% who had experienced violence by a previous partner, reported that children had seen or heard the violence.[2]Even where children do not directly witness violence, the long-term mental health effects of living in coercive environments can be significant.[3]

Children living in domestic and family violence situations are subjected to a pattern of behaviour perpetrated either directly or indirectly towards them, as a result of living with violence perpetrated against their mother. Domestic and family violence diminishes a child's immediate wellbeing, corrodes their life chances, contributes to cumulative harm including poor health, social, psychological, academic, and poor developmental outcomes. Children who experience domestic and family violence often require long-term social services provision, with an estimated cost $333 million in 2015–2016 alone.[4]

Children's experiences of domestic and family violence are a critical area for policy and practice development. [5] Australia is a signatory to the United Nations Convention on the Rights of the Child, which specifies that all children have a right to be protected and be free of violence within the home.[6] This responsibility is reflected in key statements informing Australian policy and practice implementation.

The National Plan to End Violence Against Women and Children 2022–2032 states that it is important to "recognise children and young people as victim-survivors of violence in their own right and establish appropriate supports and services that will meet their safety and recovery needs"[7]. *Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031* also identifies children and families with multiple and complex needs as a priority group.[8]

---

[1] Campo, M (2015) Children's Exposure to domestic and family violence: key issues and responses: Paper No: 36: Affiliation AIFS

[2] Australian Bureau of Statistics, Personal Safety, Australia,2012 (2013) Table 28. <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>

[3] Australia Child and Adolescent Trauma Loss and Grief Network, \2016 Stepping up for kids, Understanding and supporting children who have experienced Family and Domestic Violence <https://emergingminds.com.au/resources/stepping-kids-understanding- supporting-children-experienced-domestic-family-violence.

[4] KPMG. (2016). The cost of violence against women and children in Australia (prepared for DSS). https://www.dss.gov.au/sites/default/files/documents/08_2016/the_cost_of_violence_against_women_and_their_children_in_australia_-_summary_report_may_2016.pdf

[5] Noble-Carr, D., Moore, T., & McArthur, M. (2020). Children's experiences and needs in relation to DFV: Findings from a meta-synthesis. Child & Family Social Work, 25(1), 182–191. https://doi.org/10.1111/cfs.12645

[6] United Nations Convention on the Rights of the Child. (1989). Article 19. https://www.unicef.org.au/united-nations-convention-on-the-rights-of-the-child

[7]Commonwealth of Australian Government. (2022). National Plan to End Violence Against Women and Children 2022-2032. https://www.dss.gov.au/sites/default/files/documents/11_2022/national_plan_to_end_violence_against_women_and_children_2022-2032.pdf

[8] Commonwealth of Australian Government. (2021). Safe and Supported: The National Framework for Protecting Australia's children 2021–2031. https://www.dss.gov.au/sites/default/files/documents/12_2021/dess5016-national-framework-protecting-childrenaccessible.pdf

Glossary of Terms

Client

In the context of this practice framework, the term client, refers to a child/children or young person/young people who seek services from a domestic and family violence shelter with their mother. In some contexts, the term client will refer to the mother but will be noted specifically. Clients are children aged between 0 – 18 years old presenting to a service, or as part of a family presenting to a service, either in person or as part of the family unit. Children who do not present to the service but are part of the family unit, will also be considered as clients and have their needs and safety considered as part of the service or intervention.

This does not ignore the fact that in some situations, domestic and family violence shelters also have clients who 18 years of age and seeking refuge from violence with a young child or in their own right. Individual considerations and interventions will be adapted to meet the specific needs of the young person, particularly if they are presenting with a child of their own as a result of the domestic and family violence.

Children and Young People

For the purposes of this framework the term "children and young people" is used to include people below the age of 18 years. While the United Nations defines a child as a person 18 years and under. Using the term children and young people, ensures the impacts of trauma in both childhood and the transition into teenage years and youth are captured and which have a profound impact on the formation of identity, physical and mental health, cognitive function and learning capacity, wellbeing and independence.[9]

Children's Practitioners

Children's practitioners are specialised positions within the domestic and family violence shelters who are responsible for responding to the needs of children and young people from point of crisis intervention to healing and recovery. Children's practitioners have the ability to engage in multiple modes of intervention in a women's shelter, or domestic and family violence service to oversee case management; crisis intervention; group work; provision of practical supports; therapeutic intervention; and outreach according to developmental needs.

Practical support

Practical support refers to the provision of material needs of the client (child or children) as a result of the domestic and family violence. This can include (but not limited to) clothes, food, bedding, school uniforms and bags, toys and games as well as arranging for health appointments, assessments, referrals, school enrolments, community activity engagement and support.

[9] Robinson, S., Valentine, K., Marshall, A., Burton, J., Moore, T., Brebner, C., O'Donnell, M., & Smyth, C. (2022). *Connecting the dots: Understanding the domestic and family violence experiences of children and young people with disability within and across sectors: Final report* (Research report, 17/2022). ANROWS.

Practical support is also provided to caregivers/parents to ensure that they provide necessities for their children. This may be provided in the form of financial resources or as already described.

Case management

Case management is defined as:

"… a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's holistic needs through communication and available resources to promote quality cost effective outcomes" [10]

More specifically and for the purpose of this practice framework it means that children/young people and their caregivers are involved in a needs assessment; material needs (school uniforms; equipment etc); connection to community/recreational activities; health needs and assessment; education assessment and school support systems and connections; safety planning. Other elements of case management children's practitioners can facilitate are:

- Engaging with the mothers/caregiver to learn more about and strengthen positive bonds with their children where these relationships have been impacted by the domestic and family violence.
- Work with children to help them make sense of their experiences, understand their feelings, manage change, and improve their social skills.
- Help to restore a child's emotional and mental health through the improved relationship with their mother.
- Work alongside the mother's case manager to offer holistic approach to managing the impact of domestic and family violence, and work towards keeping the child (ren) visible throughout the intervention.

Outreach

Outreach is broadly described as comprising responses that support domestic violence survivors in their homes and communities providing accessible and flexible points where information about service provision, and follow-up contact are available[11]. Approaches to outreach are generally developed and implemented with broad social aims of building awareness, and growing trust and mutual understanding and to create pathways into communities for communicating service information, to enable service users and communities to influence and shape service responses, and to fashion ways to overcome barriers [12] Outreach can involve visibility, availability, and discretion.

[10] https://dhs.sa.gov.au/__data/assets/pdf_file/0006/143988/Case-Management-Framework.pdf
[11] Kelly, L., & Humphreys, C. (2001). Supporting Women and Children in Their Communities: Outreach and Advocacy Approaches to Domestic Violence. In J. Taylor-Brown (Ed), What Works in Domestic Violence Intervention? (pp. 231-271). London: Whiting and Birch.p 231.
[12] De Prince, A., Belknap, J., Gover, A., Buckingham, S., Labus, J., Combs, M., … Pineda, A. (2012a). The effectiveness of coordinated outreach in intimate partner violence cases: randomized, longitudinal design. Washington D.C

Shared understandings

This section ensure that the concepts used in this practice framework is reflective of shared understandings of those concepts.

Domestic Violence (including coercive control)

Domestic violence refers to acts of violence that occur between people who have or have had an intimate relationship. The central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise and control women and their children and can be both criminal and non-criminal.

There are common categories of abusive behaviour described across the literature, and by survivors of domestic violence, which includes violence and abuse that is: physical; sexual; psychological and emotional; social; financial; spiritual and faith based, and technological abuse. Women and children may experience all or some of these forms of violence and abuse; and the type, frequency and level of risk associated with these forms of violence can change over time. Children may bear witness to the abuse of their mother, or directly experience violence.

Domestic violence is the term used to encompass the range of violent, coercive, threatening and controlling behaviours that are perpetrated, predominantly by men against women and their children in current or past intimate relationships.iThe central element of domestic violence is an ongoing, intentional pattern of behaviour aimed at controlling a partner through fear.

Domestic violence is experienced by women and their children from all parts of society, regardless of their culture, age, sexuality, socio-economic background, education level or ability. While there is not a single cause of violence against women and their children, there are certain factors that consistently drive higher levels of violence against women which include: beliefs and behaviours that reflect disrespect towards women, low support for gender equality and adherence to rigid or stereotypical gender roles, relations or identities used to encompass acts of self-harm and suicide and has become widely adopted as part of the shift towards addressing intra-familial violence in all its forms.

Family Violence

Family violence is a broad term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for domestic violence but includes any violent or threatening behaviour that coerces or controls another family member or causes that family member to be fearful that is identified as a pattern of ongoing behaviour. The term family violence is inclusive of children being violent to parents, mothers and fathers being violent towards children, violence between siblings and violence between extended family. Family violence is the most widely used term to identify the experiences of Indigenous people because it includes the broad range of marital and kinship relationships in which violence may occur.

Practice Foundations

This children's practice framework draws from practice foundations that are generally agreed to and practiced within the domestic and family violence service sector. These foundations underpin practice in this context and are reflective of some of the core themes that emerged from conversations with practitioners.

United Nations Convention on the Rights of the Child

Children who live in families where domestic and family violence is present is a contravention of Article 19: UN Universal Rights of the child which states that:

"State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child"

The United Nations Convention on the Rights of the Child operates with 4 key pillars which include: non-discrimination, the best interests of the child, the right to life, survival and development and respect for the views of the child.

Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment, and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement. [13]

Social justice

Taking a social justice perspective to human service work aims to provide equity in the distribution of resources and services, have consistent promotion of inclusivity, diversity and lead to having genuine participation and voice in the decisions affecting their lives. There are four key principles required to work with a social justice perspective:

- **Human Rights:** An important principle of social justice is the idea that everyone deserves basic human rights. These rights generally include life, food, safety, and education.
- **Access:** This principle states that all individuals should have access to opportunities. No one should be restricted from things like education or healthcare due to their race, income, age
- **Participation:** Participation in terms of social justice means that marginalized populations have a seat at the table and are empowered to state their needs.
- **Equity:** is a way to achieve equality by recognizing existing inequalities and ensuring that everyone gets a fair chance.

[13] NCRC Article 19 https://www.unicef.org.au/united-nations-convention-on-the-rights-of-the-child

Intersectionality

Intersectionality is an important practice foundation to apply in the context of domestic and family violence considering the complex nature of the issues faced by women and children. The current definition from ANROWs is applicable and accepted in the sector from the Our Watch Intersectional Strategy (2018 – 2020):

Intersectionality acknowledges that while gender inequality is a necessary condition for violence against women, it is not the only or necessarily the most prominent factor in every context. Violence against women and children is often experienced in combination with other forms of structural inequality and discrimination. Examining how other forms of structural inequality and discrimination intersect with gender inequalities to exacerbate violence is necessary to effectively address the root causes of violence against all women, across the diversity of the Australian population. [14]

Intersectional risks can be shaped by a range personal and structural factors in conjunction with a client's lived experience of DFV which include:

- Racism and/or discrimination
- Misunderstanding and ignorance
- Homophobia, biphobia, transphobia and intersex phobia
- Institutional or interpersonal prejudice, including faith-based prejudice
- Economic disadvantage
- Mental illness
- Disability
- Trauma associated with migration or pre-migration experiences
- Prolonged experiences of discrimination and disempowerment
- Childhood trauma and trauma associated with past experiences of family violence
- Sexual assault.

An intersectional approach ensures that services are accessible, inclusive, respectful, non-discriminatory and responsive to the diversity of the child/ren.

[14] Our Watch: Organisation Strategy to Strengthen our Intersectional Approach 2018 – 20 https://assets.ourwatch.org.au/assets/About-us-documents/2018-20-Intersectionality-Strategy.pdf

Practice Approaches

This practice framework draws from a range of current, and evidence-based approaches to best meet the needs of children in the domestic and family violence services. Children's practitioners (in partnership with the child's mother and mothers case manager), aim to ensure that the child/children feel comforted, nurtured and safe to begin their journey of engagement and healing. Children's practitioners will have knowledge and expertise in each of these approaches and tailor their work considering the individual circumstances, identity, developmental age and needs of the child/children. It is acknowledged that these approaches may be revised, or updated as new research evolves.

These practice approaches are generalised to be transferrable across a range of service settings including shelters, child wellbeing programs within domestic and family violence services and other settings where practitioners are working with children.

Safety First Approach

A safety-first approach is critically important for the women, children and young people who seek refuge from domestic and family violence. For the purposes of this practice framework, it means that child (ren)s safety is the priority and embedded within all aspects of service delivery. Safety first includes both physical and emotional safety for all members of the family (including pets) presenting to the service. Consideration of the safety of the children not presenting to the service but under the care and affected by the domestic and family violence is also important. A safety-first approach includes an awareness of immediate safety and consideration of longer-term safety.

Safety first requires implementing strategies that are responsive to the child/children's unique situations, the perpetrator behaviour, the status of the relationship and the point in-time that the client connects with the service. A safety-first response considers the specific vulnerabilities and protective factors that each individual client has, and the high-risk periods for women and children, for example, at the point of leaving a relationship or after separation. Safety first also means hearing from the children about what safety means to them and supporting the development of safety management strategies tailored to their circumstances, culture, identity and needs.

Safety first involves taking a culturally responsive approach to holding the perpetrator accountable for the violence and restraining their ability to continue to perpetrate violence. For First Nations people, perpetrator accountability is understood in the context of culture and loss of culture and the importance of community and traditional laws and roles.

A safety-first approach also understands that a child(ren) are reliant on the actions of their mother and are not responsible for their own safety. It also recognises that the actions of the perpetrator are not their responsibility. This tension can lead to inconsistencies and challenging determinations of risk and the safety-first approach is reliant upon collaboration between the mother's case manager and the children's practitioner. A safety-first approach considers the risk factors for the whole of family unit and works to consider safety plans that are complementary to children's needs, and which do not place children at additional risk.

Child Centred Approach

Child-centred practice means giving priority to the needs and welfare of the child, promoting the child's right to participate in the process of assessment and decision-making. It involves listening to children, building relationships with them, spending time to respond to their questions and enabling them to express their views. A child-centred practice involves seeing the world through their eyes, understanding their sociocultural context and influences, gaining an understanding of what their lived experience is like in the context of domestic and family violence and the presence of other risk factors that impact on their lives. In complex situations it is imperative to work with the carers/parents to reduce risk which means facilitating interventions for change with the family and still not losing sight of the needs and rights of the child (See WSSSA practice framework).

A child centred approach is informed by the child rights of non-discrimination, the best interests of the child and knowledge about development where the needs of children and young people are evaluated which will, in turn, shape practice accordingly (See separate section on "Developmental Approach"). This approach also recognises the importance of intervening in early in children's lives 15. A key element of a child centred approach is to offer a sense of stability and gaining understanding from the children about how they want to be spoken to, how they would like to be acknowledged and seen.

The importance of relationships sits at the heart of being child centred. The ability to establish trusting relationships enable practitioners to be responsive to the unique needs of each child and young person which facilitates safety, healing and recovery. The importance of ensuring that children and young people are connected to important people in their lives and that they are safe and stable is a critically important element of being child centred16

Developmental Approach

Contemporary research and discussions with practitioners have highlighted that understanding child development and ensuring that a developmental approach informs practice is mandatory. Child development is the biological, psychological and emotional changes that occur in human beings from birth and beyond. It is a process that occurs within and influenced by the social and cultural context where infants are completely dependent at birth and move towards increasing independence and autonomy. Understanding development means considering physical, socio-emotional, and cognitive creative development and every child's development trajectory is unique and dependent on diverse experiences, availability of opportunities, trauma, and parental capacity.

[15] Robinson, S., Valentine, K., Marshall, A., Burton, J., Moore, T., Brebner, C., O'Donnell, M., & Smyth, C. (2022). *Connecting the dots: Understanding the domestic and family violence experiences of children and young people with disability within and across sectors: Final report* (Research report, 17/2022). ANROWS.

[16] Bastian, C' Dunk-West, P. & Wendt, S. (2021) Being child centred: factors that facilitate professional judgement and decision-making in child protection. Child & Family Social Work 2022, 27: 91-99

"In essence this means, that workers should be mindful of the developmental status and history of the child or young person under their care" (Fernandez & Delfabbro, 2019) [17]

At its most basic, embedding a developmental approach means that children's practitioners are knowledgeable about normative development and what is required by each child in critical period of grown in the pre-natal, neonatal and early childhood years and subsequent development and psychosocial functioning. Understanding normative development and what is expected at each stage informs assessment, modes of communication and interaction, and intervention strategies. For example, models of communication and approaches to assessment will differ for a child who is two years of age compared to a fourteen-year-old young person. On this basis it is evident that children's and young people's developmental needs change over time and what is important in one developmental stage will change in another.

A developmental approach is not just about age but means that children's practitioners must consider the diversity that exists among children in relation to age, gender, cultural background, and family background. In addition, it is essential that children and young people's vulnerabilities are considered in relation to assessment of their needs and responding to those needs. For example, vulnerabilities such as living in out of home care, complex behaviours, disabilities (global developmental delay; physical disability; intellectual disability), trauma responses, and health needs impact on "normal" developmental journeys and impact on intervention for safety, healing and recovery.

Trauma Informed Approach

Children and young people exposed to violence in the home are particularly vulnerable due to their limited power to influence decisions about their lives having a profound impact on their physical, psychological and emotional health and wellbeing. Child abuse trauma has a detrimental impact on the developing child, particularly on the neurological development of infants.[18]Childhood trauma can also affect early attachment dynamics and interrupt the development of secure attachment relationships that support healthy child development and are considered to be the foundation of healthy adult functioning.[19]

For these reasons, it is important to recognise the impact of trauma on the child/ren's current, and future development and aim to minimize re-traumatising children through their interactions with a service. This includes the children's practitioner (in partnership with the mother's case worker), supporting the mothers' confidence and ability to understand the impact of violence upon children's health and wellbeing.

The children's practitioner can support the mothers understanding of how trauma can manifest in behaviour and attachment. Part of the practice can seek to elevate the position of the mother in the family to (re)build a sense of security and belonging for children, and to (re)build meaningful, healthy family routines and rituals, and problem-solving strategies. A children's practitioner trauma informed approach will work at a pace that suits the child/ren.

[17] Fernandez, E., Delfabbro, P., Ramia, I.O. & Kovacs, S., 2019, 'Children returning from care: The challenging circumstances of parents in poverty', Special Issue, Children & Youth Services Review, vol. 97, pp. 100–111

[18] Campo, M (2015) Children's Exposure to domestic and family violence: key issues and responses: Paper No: 36: Affiliation AIFS

[19] Ibid (2015)

Principles of a trauma informed approach incorporates approaches that centre the child and young person in all aspects of case management including:

- Safety first
- Ensure that assessments are strengths focused
- Children's practitioners to demonstrate their trustworthiness and transparency
- Collaboration and empowerment where all decision making, and goals are shared
- Providing opportunities so that children and young people have voice and able to have choice
- Knowledgeable practitioners, and
- Inclusive of culture, gender and diversity.

Culturally Responsive Practice

In the context of working with First Nations children and young people, any practice or intervention should place cultural safety at the centre and help children and young people develop a positive identity through connection to culture, family, kin, community and country. Importantly, there must be recognition of the impact of colonisation on Aboriginal children and understanding intergenerational trauma in the context of domestic and family violence. Furthermore, there is acknowledgment and recognition of diverse communities within Aboriginal culture and any practice or intervention should include consulting with Aboriginal staff and family members. Through a child centred practice, there should be recognition of Aboriginal kinship systems, and family relationships which support any decisions or interventions that may be necessary for the safety and wellbeing of the child (ren).

More specifically, cultural safety for First Nations children means that:

> *"… the child being [is] provided with a safe, nurturing and positive environment where they are comfortable with being themselves, expressing their culture…their spiritual and belief systems, and they are supported by the carer… (who) respects their Aboriginality and therefore encourages their sense of self and identity."* [20]

Cultural safety for Aboriginal children and young people is inextricably linked to their sense of self and that is valued by the people who are in their lives [21]. Aboriginal children and young people who have a clear sense of self and identity are connected and immersed in their culture which is critically important for those children and young people involved in the child welfare system. Aboriginal culture includes family networks, Elders and Ancestors. Culture is relationships, languages, ceremonies, and heritage[22]. Culture can further be defined as the spiritual connection to country, the knowledge passed on to them. Culture is all-inclusive holistic component for Aboriginal people's daily lives. Without even one component of Aboriginal Culture accounted for children and youth in Care their wellbeing and health will deteriorate and suffer. Cultural disconnection or the absence of it is a risk factor for their health and wellbeing[23]

[20] https://www.snaicc.org.au/wp-content/uploads/2021/11/211101_8_National-Framework-Protecting-Australias-Children.pdf
[21] https://www.vacca.org/content/Document/VACCA_Annual_Report_2010_to_2011.pdf
[22] (Jackomos, 2015)
[23] (Kickett, 2019).

Who are the Children?

There is extremely limited information providing details about children and young people who seek and provided services from domestic and family violence shelters. Children presenting to a service can be a range of ages, gender identities, abilities, and cultural background. These variations play a significant role in the approach needed for the children's practitioner, particularly if there are very young children or babies. Children will also present to the services at varying levels of knowledge about the domestic and family violence and trauma, and depending on the point of crisis, may be with or without material items to function in their daily lives.

Furthermore, children presenting to shelters have experienced:

- homelessness
- school issues (non-attendance; poor performance);
- behaviour issues (withdrawn; aggressiveness; fearful)
- mental/emotional distress (i.e. bedwetting; soiling);
- disrupted relationships inability to settle or concentration and learning difficulties;
- disrupted sibling relationships and separation anxiety,
- maternal alienation,
- parent-child conflict,
- self-harm and suicidal ideation,
- parentification of children,
- diagnosis of PTSD, r
- risk taking, and
- engagement in criminal behaviours[24]

A significant and growing presentation of many children is the varying range of disabilities (both diagnosed and undiagnosed) and increasing numbers of children presenting with autism spectrum disorder and ADHD. Children presenting with disabilities are particularly challenging within emergency accommodation where there is limited scope for emotional regulation outside of the motel room. All types of children have difficulty regulating their emotions, but the children with ASD and ADHD have particular challenges.

Children's Practitioners

Children's practitioners are required to respond to the complex and diverse safety and wellbeing needs of children and young people who reside within the domestic and family violence shelters. Practice responses must be informed by knowledge and skills that are child centred, domestic and family violence and trauma informed.

The children's practitioner has primary responsibility to be child focused and implement interventions according to the child and young person's needs from the moment they are accommodated within the domestic and family violence shelter. This means responding to their crisis and safety needs right through to promoting healing and recovery in a therapeutic and nurturing environment. This also means that responses need to be culturally responsive and ensure that children and young people are connected to their family, culture and community.

24

Assessments must be inclusive of the socio-cultural context within which the child lived, the perpetrator's behaviour and the impact of that behaviour. Comprehensive assessments will inform and shape intervention plans that are responsive their unique needs from the point of crisis right through to healing and recovery. In addition, the children practitioner must simultaneously differentiate themselves from the women's case manager and work alongside the women's case manager, case workers to ensure a holistic and comprehensive assessment and intervention plan is implemented.

Children and young people will have their unique needs and they deserve to have those needs met and reduce the long-term impact of trauma. Their needs may also include a response to the fractured parent-mother/carer relationship because of coercive control and violence.

Governance for children's practitioners

The role of children practitioners needs to be supported by clear governance within the domestic and family violence shelter workforce structure. A clearly identified structure demonstrates and positions the importance of children and young people within a structure that has been traditionally adult focused. The following is required:

- Established children's practitioner roles and functions in every domestic and family violence shelter that is responsive to the demand of those organisations.
- Identified and allocated funding that facilitates the recruitment and retention of children's practitioners who can respond to the unique needs of children and young people from crisis right through to healing and recovery, outreach, and in collaboration with other agencies.
- Establishment of the role of a Senior Children's Practitioner that oversees professional responses provided by children's practitioners to children and young people across all domestic and family violence shelters.
- The Senior Children's Practitioner will have specialised knowledge and skills in working with children and young people and is responsible for operationalisation of the roles and provision of education, training and professional supervision.
- Established mechanisms within the organisational structures to ensure that children's workers engage in reflective learning opportunities.
- Available funding to ensure that children's practitioners can attend professional development opportunities to ensure they have the relevant knowledge, skills and experience.

Working with Children

The role of a children's worker has the capacity to deliver evidence based early intervention work as key element to breaking the cycle of violence. Working with children begins at the referral/intake process and first meeting with the mother. Gaining an understanding of the needs of the child (ren), their developmental level whilst working during a time of crisis, require children's practitioners to be flexible and adaptable in their approach, adopting a safety-first approach whilst attending to the varying needs of the child(ren) and working collaboratively alongside the mother's case manager.

When working with children, practitioners need to follow the principles of case management which include:

- Establishing safety
- Safety assessment
- Intake assessment
- Shared goals and decision making
- Healing and Recovery

Other key elements need to be considered when working with children include:

- Noticing children's behaviours that signify trauma as oftentimes, children are unable to verbalise their feelings and have low levels of emotional literacy and developmental skills gaps.
- Being aware of what is being said by the mother in front of the children (and how they respond) as a way to gain understanding of their knowledge of the domestic and family violence and their trauma to
- Being skilled at navigating complex conversations about contact with the father/perpetrator with both the child and the mother.
- Being aware of changes to living conditions for the children which can alter a child's behaviour therefore adapting the intervention.
- In some circumstances role modelling care for children/parenting and offer basic care needs to children as a way of supporting the mother.
- Gaining consent from the mother to work with the children. In some circumstances, the mother may be hesitant to work with children's practitioners due to fears or child removal due to limited parenting skills.
- Being mindful that children can take their time to develop trust and connection due to their distrust of adults as a result of the domestic and family violence.
- Navigating the complexity of the older teens who would benefit from the service, but mother may not give approval out of fear of what the child (teen) may reveal.
- Recognise and consider that late teens early 20's clients may have developmental delays and although they are presenting as aged out of the children's service, they will be expected to respond like an adult to their situation. In some instances, these late teen's, young adults may be presenting with their own children.
- Understand the right time to put in place therapeutic supports on the continuum of crisis response.
- Recognise the importance of belongings for children regardless of the age of the child.

- Understand the family dynamic and conflict of interest if child wants to work towards goals that are not aligned with mum or siblings.
- Understanding that mum may not recognise the trauma of their child due to their own trauma.
- Recognising the conflict that the children feel if they are still required or want to visit Dad, and the emotions that come with seeing their belongings if they cant take them
- Meeting the child at their level, not looking down on them or condescending, being very present with the children
- Navigating the continued trauma of keeping the children away from their normal life – sports, school etc to keep them safe (in the eyes of mum)
- Recognising that all the work is therapeutic, but when it is the best time to refer out.
- Work at the child's pace, not an adult interaction.
- Need to establish reliability and credibility.
- Acknowledge that simple things can be therapeutic for children such as walking or playing.
- Recognise the developmental limitations of young mothers that come to the service and adapting the response to their needs rather than expecting the response to be in an adult bracket.
- Recognise the importance of stability, that comes with the shelter, but also recognise this can be short lived as it becomes harder for family because friends and family can't visit.
- Meet children in places that they are comfortable and safe such as at school, or for older children at a café or out somewhere or walks, include play therapy to incorporate into something normal.
- Engage in multiple modes of intervention within a women's shelter or domestic and family violence service such as: case management, crisis intervention, group work, provision of practical supports, therapeutic intervention, and outreach according to developmental needs.
- Have knowledge of the intersection of domestic violence model and trauma informed child centred practice
- Understand power and control from the perspective of the child, given they have little to no power to control their circumstances. Find ways to give the child decision making capacity to regain some control over their own life.
- Take a strength based validating approach with the child.

Functions of children's practitioner

There are some key functions practitioner can do to support the children (but not limited to):

- On intake, provide a safe place for the child to feel supported physically and emotionally.

Create space and conditions for emotional regulation.

- Aim to meet the child's basic material needs such as food, clothing, access to their belongings if possible, and if in women's shelter, try to create their own space.
- Provide opportunities in the intervention practice for the children to be children. Provide age-appropriate play therapy, music, toys for reframing and developing trusting safe relationships.
- Offer developmentally appropriate interventions rather than presenting age.
- Engage in therapeutic intervention for healing and recovery.
- Provide counselling at the point of crisis for the child to understand why they are in shelter/service.
- Allow the child or young person to discuss their own feelings and thoughts letting the practitioner know what supports they need.
- Name the domestic violence for the children in an age-appropriate way, allowing the children to have big feelings and guiding them how to express themselves without being scary or dangerous.
- Provide psychoeducational opportunities to learn about domestic and family violence using age-appropriate language and concepts. Educate the children to name the DV understanding that what is happening is not okay and not their fault.
- Safety plan and provide information for children for father visits, or if mum goes back to the relationship.
- Provide the children with tools to self-regulate, to better manage when they go home and thinking and feeling in a safe way.
- Make warm referrals to other services relating to health and other services for assessment.
- Safety plan with education/school to ensure that perpetrator is known to schools and that children are considered with interventions orders. Understanding the grief and loss when changing schools for the children around friends.

Working Alongside Case Manager

Children's workers play a significant role supporting the mother and working collaboratively with the case manager. Often when mothers are supported with their children, and trust is built, they can focus their attention on better understanding the child's trauma, and their own.

Working alongside the mother has shown to have benefits for both the children and mothers' wellbeing, particularly in strengthening family relationships, emotional safety, and safety planning. Other benefits include improved ability of the mother to be aware of behaviours that are as a result of the trauma, and to have insights into understanding their behaviours. Routines for the children can be established and maintained more easily if the mothers are involved in the conversations with the children's worker.

Some key functions for working alongside the mother's case manger are:

- Check in regarding potential violence toward the children from the mother
- Be mindful of personal values with mothers and they way they parent.
- In shelters, bring activities to the families as trust a big issue for the mothers for outside activities.
- Support making connections and link the child to education and local/community activities to maintain normal routine and reestablish connections in their lives
- Facilitate opportunities for women's case manager to understand the developmental damage of children's trauma.
- Help support mum with basic living skills where possible.
- Check for protective factors for the children such as being in school or childcare.
- Check in with mum about basics, diet, sleep, friendships, school attendance and behaviour.
- For First Nations children, provide and facilitate cultural safety for the child and family, working alongside case manager and seeking cultural connection and advice from family and kinship groups

Other important Practice Elements to consider

- Pets
- Interface with Child Protection – home visits and school visits

Can we give this practice manual to other workers in settings such as DCP/Schools/Hospital settings etc. Supporting external services and organisations (ie: like education) to understand the impact of the DV on the child (ren) and how that could show up in a school setting?

Closing out the service/other recommendations

- Possibly continue to work with the children after case management has closed with mum and housing achieved
- Specific children's worker supervisor role
- Good practice to have debriefing and supervision.
- Shifting the perception that children don't need a lot of intervention.
- Important to be reflective.
- Knowledge mostly self-directed – make recommendations about this at end of doc