Adelaide Psychological Services

10 August 2024

Hon Stott Despoja

Royal Commission into Domestic, Family and Sexual Violence

Submission to Royal Commission into Domestic, Family and Sexual Violence

Dear Commissioner,

This submission is made from the perspective of a mental health clinician who has 28 years' experience working both in a state community mental health team for adults who experienced an episode of severe mental illness, and in private practice. My experience involves assessing and treating members of families who have been exposed to domestic violence and maltreatment. I have experience in working with families where children are vulnerable to developing a mental disorder due to their exposure to domestic violence and to other parental risk factors.

I note that domestic violence is addressed by a range of services including by: family law courts (FCFCoA – Federal Circuit and Family Law Court of Australia), the Youth Court and Department of Child Protection (DCP), police, Magistrate Courts, mental health services, emergency departments of hospitals, private mental health therapists, and non-government agencies. There are questions about optimal ways to coordinate an overall response when a notification is received about an incident of domestic violence.

This submission has a special focus on cases where an allegation of family violence has been made, where a parent shows symptoms of a mental disorder including anxiety and depression, and where DCP becomes involved following a mandatory notification by a health professional or a teacher.

Qualifications to provide submission

My qualifications to provide this submission follow.

I am a registered psychologist with endorsement as a clinical psychologist.

In my early career from ████ to ████ I worked as a psychologist in the New Zealand Justice Department, working with offenders who were imprisoned following conviction for domestic violence.

From ████ to ████ I worked as a consultant psychologist in a large agency ████████ that provided residential services for people with an intellectual disability. The agency provided in-home educational support for parents who kept their disabled child at home. Many clients had additional diagnoses of anxiety, autism spectrum disorder, attention deficit hyperactivity disorder, and conduct disorder. Much of my work was as a consultant who was involved in assessing clients and giving advice to disability support workers and parents about strategies to manage the behaviour of clients, as well as directly providing services.

From ████ to ████ I worked in an adult community mental health team located in ██████████ ████████ SA. At the time, almost 30% of clients of █████ █████ were mothers who were custodial parents of dependent children. The team received a grant from the SA Health Department to review literature and to develop and implement a program to improve parenting practices of parents with mental illness. The team had access to funds to employ disability support workers who worked in collaboration with clinicians to provide an in-home parenting coaching service, in clinician-led therapy. The █████ program was implemented over a period of about 8 years. █████ Clinic provided a clinical case management approach for families including where there was a risk of family violence. In the clinical case management model, a clinician who provided most therapy services also liaised with providers from other disciplines and agencies who delivered other services. The clinical case manager ensured the coordination of service delivery to a client and to the client's family. Clinical case managers typically had a caseload of about 30 clients.

From ████ I have worked in a group private practice. I continue to work with vulnerable families, including families who have cases before a Family Law court and before the Youth Court due to child protection concerns. I provide treatment reports to courts.

I have twice given presentations to the World Congress on Family Law and Children's Rights on the topic of treatment reports for courts.

I have been approached by an international publisher to edit and write about experience in Australia in supporting families where children are vulnerable to developing a mental disorder. An edited book is in press entitled 'Psycho-legal concepts for parenting in child custody and child protection.' The publisher has decided to publish my book as a series of four volumes.

OVERVIEW

This submission proposes that it is important to divide interventions that aim to minimise family violence into categories such as prevention, early intervention, immediate response, and recovery / rehabilitation. To achieve this categorisation, it is essential to introduce an evidence-based category system that is based on identification of risk factors for violence by individuals.

It is proposed that the four categories be associated with four levels of intervention, and that distinct providers be recognised as capable of delivering each level of intervention.

This submission offers proposals on the following topics:

a. what an evidence-based category system might look like,
b. types of intervention for each category,
c. barriers to delivery of early intervention and rehabilitation services.

Issues and barriers

The Commonwealth Government has published a policy document 'National Children's Mental Health and Wellbeing Strategy' that aims to improve the mental health of children by improving access to therapy / rehabilitation services. The Strategy identifies two cohorts of children who are at increased risk of developing a mental disorder themselves; parents with a mental illness, and children whose family are referred to a child protection service. The Strategy calls for improved early intervention therapy for these cohorts of vulnerable children.

As discussed throughout this submission, I consider there are many barriers that inhibit mental health therapist from working with children who are vulnerable due to their exposure to family violence. A number of structural changes are needed to support the delivery of evidence-based therapies to families where children are vulnerable due to their exposure to family violence.

My submission addresses topics raised in the Issues Paper.

A - PREVENTION

Q1 - What causes domestic violence?

The aim of focusing on prevention is to provide cost-effective interventions for families where there is some risk of domestic violence, before violence occurs and adults and children are harmed.

This submission proposes that the topics of Early Intervention, Immediate Response, and Recovery and Healing can best be addressed by introducing a state-wide data management system that records risk factors for domestic violence in individual cases.

As discussed further below under Question 4 about Early Intervention, an adequate data management system can be developed that will assign people who are notified into at least four main categories:

a. **No-risk** of family violence, where people have access to universal interventions that are available for the whole population.
b. **Low-risk** of offending, where people require a preventive approach or an early intervention approach where there are risk factors, and before offending occurs.
c. **Medium-risk** of offending, where people require an individualised therapy / rehabilitation approach that is targeted to address identified risk factors.
d. A **high-risk** of offending or has-offended significantly, where people require a legally mandated restrictive approach.

Common scenario

A scenario that is common in my experience commences when a child misbehaves and their parent struggles to manage their child's behaviour. Cycles of interactions occur, called dynamics. The child's behaviour might be reactive to the child observing angry arguments

between their parents. Parents might argue about parenting methods they use with the child, and arguments might escalate into emotional abuse and perhaps physical violence. One parent (often a mother) becomes distressed and disinhibited and uses childrearing methods such as shouting at their child, that the parent later regrets.

A distinction is made between an offending parent and a protective parent. A child might be injured by an angry parent, and the protective parent takes the child to a hospital emergency department for assessment and treatment. The protective parent might arrive at the hospital in a distressed state.

Emergency staff at the hospital make a mandatory notification to DCP as they see indicators that support a suspicion that domestic violence might be occurring in the household. While hospital staff are mandated to make notifications of children at risk of harm, they are not currently mandated to refer vulnerable families to any form of therapy, so this opportunity to provide early prevention is missed.

Various scenarios can occur.

A parent might engage in inappropriate coping with stress in the household by temporarily using illicit substances.

One parent might leave the household and then seek regular access to their child. The two parents might make mutual allegations about inappropriate parenting practices used by the other parent, and their dispute is referred to the Family Court.

One or both parents might seek personal therapy from a Medicare funded psychologist. The psychologist makes an assessment and decides whether to provide therapy for one family member, or to offer joint therapy to a parent-child dyad. If the case proceeds to one of Australia's family-oriented courts, then the psychologist might receive a subpoena to provide notes about confidential information to the court, or the psychologist might be asked to provide a treatment report to court. I note that the possibility of a subpoena deters many competent psychologists from providing therapy for members of vulnerable families.

In a further scenario, a notification is made to DCP and DCP begins an investigation. DCP might discover that a child is exposed to further risk factors including: the custodial parent is exposed to several stressors and is struggling; the custodial parent is isolated from family support; the parent has not ceased contact with their partner who offended; the parent has a past history of misusing substances; the custodial parent was themselves placed into out-of-home care as a child and there is doubt about whether the parent has learned a healthy parenting template; and so on.

If DCP identify a number of concerns about a family, they are likely to raise concerns that the child is exposed to a risk of cumulative harm, and to apply for an order for the child to be placed in out-of-home care while the department conducts further investigations. DCP might be reluctant to acknowledge that restricting a child's access to its parents produces further trauma for the child. DCP might keep a traumatised child in out-of-home care for periods of two years and more while they conduct investigations. If DCP attributes the child's trauma-related behaviour to the previous care provided by the parents, rather than to the child being removed from parental care, then DCP might not arrange any form of therapy for the child. Some children who were placed in out-of-home care and denied regular access with their parent develop an enduring anger problem and resentment towards society.

Q2 – What works to prevent ongoing domestic violence?

This section examines a question of whether researchers agree on parenting approaches that minimise use of domestic violence.

Parenting styles

Diana Baumrind in the 1950s introduced a concept of 'parenting styles' based on two dimensions of parenting; warmth and directiveness. The Baumrind approach identifies four main parenting styles as summarised below:

a. a **supportive and firm** (originally called authoritative) parenting style that combines emotional warmth with directiveness,
b. an **authoritarian** style provides little warmth and high directiveness using strict guidelines and punishment to obtain compliance with a parent's instructions,
c. a **permissive** style provides high warmth but little guidance or directiveness as parents set few limits on their child's behaviour,
d. a **disengaged** style provides little warmth or guidance and does not teach a child to develop self-control.

Subsequent research has identified the authoritarian parenting style as being associated with use of violence by parents, and as teaching children that family violence is acceptable.

A Positive Parenting Program (Triple P) introduced by Professor Matt Sanders from the University of Queensland promotes the authoritative parenting style with an emphasis on settling limits on children's behaviour, and on use of methods of positive reinforcement including praise and use of physical rewards over use of punishment to discipline children.

Alternative parenting programs emphasise the importance of parents forming an attachment bond with their child. A Circle of Security model of parenting emphasises a parent's sensitivity and responsiveness to their child's emotional cues, and can be interpreted to encourage gentle parenting that is interpreted by parents as meaning that a good parent doesn't allow their child to become distressed.

While theorists agree that parenting practices need to change as a child enters each new stage of development, no stages-of-parenting approach has become dominant.

While theorists agree that parenting needs to be adjusted to the needs of each individual child including to a child's temperament, no temperament-based parenting approach has become dominant.

Overall, researchers have not reached consensus about parenting practices that discourage children from learning to use violence in relationships, beyond avoiding use of physical violence by parents and discouraging a harsh authoritarian parenting approach.

Prevention interventions

Preventive interventions that can be taught universally to adults through mass media and groups could deliver information about:

i. Red flags that a partner might engage in family violence
ii. Types of domestic violence
iii. The cycle of violence
iv. Coercive control
v. Disadvantages of using harsh punishment with children
vi. Disadvantages of using a permissive parenting style, an over-protective parenting style, and a disengaged parenting style with children.

Universal positive parenting practices

This submission proposes that there are a range of parenting practices that will teach children to exercise self-control and will reduce use of violent and over-intrusive childrearing practices by parents.

Universal positive parenting practices can include:

i. Teach parents to build an **attachment bond** with their child.
ii. Teach children to identify hazards in their life and to manage risks by teaching **safety skills** for hazards the child regularly encounters and can learn to manage, such as crossing a road and using a sharp knife. A parent who teaches safety skills to their child is less likely to become alarmed by their child's unsafe actions and to over-react.
iii. Teach children to **use words** to describe common hazards and their emotional reactions, such as 'hot' to describe a hazard, and words such as 'hurt' when a child has been harmed.

Data system to identify levels of risk of offending

This submission proposes that the best way to prevent ongoing domestic violence is to have a data system that identifies individuals who are at increasing levels of risk of engaging in types of violence (domestic violence, sexual abuse, physical abuse, emotional abuse, and neglect).

A suitable data system records information that assigns individuals to a classification system that provides about four levels of intervention that can be delivered progressively, such as proposed in the National Framework to Protect Australia's Children (2009). Levels of intervention can be labelled: universal prevention / early intervention / individualised rehabilitation therapy / restricted access to another person.

To be effective in predicting likelihood of future offending by individuals, a data system needs to be capable of performing the following functions:

a. Record occurrence of specific substantiated **risk factors** that increase **likelihood** of maltreatment based on scientific studies.
b. Record identified **protective factors** that reduce likelihood of risk based on scientific studies.
c. Categorise the **severity of risk** arising from **impacts** of each risk factor, using about a 4-point scale of severity such as: mild-impact / moderate-impact / severe-impact / unacceptable-impact.
d. **Compute likelihood** that an adult will offend in the future by using a formula that adds likelihoods based on established risk factors and protective factors.

e. Set **thresholds** to refer individuals to relevant intervention programs.
f. Provide **indicators** to refer adults and children to specific interventions that **target** identified risk factors for each type of abuse (domestic violence, sexual abuse, etc).
g. Record that an individual has been notified of their risk assessment, and **referred** to an appropriate intervention program following an assessment.

Note that this proposal makes a distinction between the **likelihood** of a risk and the **severity** of impact of a risk factor.

In medicine, doctors use a comparable data base to predict survival rates of women who have been diagnosed with breast cancer.

The task of setting a threshold for intervention is important when using a statistical approach. Setting a threshold too high will result in vulnerable people not receiving an intervention they require. Setting a threshold too low will result in a high number of people being referred for unnecessary interventions.

I consider that the task of managing this type of data system is best performed by statisticians.

Q3 – Existing initiatives

The South Australian Government has not endorsed any parenting style or parenting approach to be taught in state services. The Government does not evaluate efficacy of interventions provided by state funded bodies, including DCP.

The South Australian Government has not yet endorsed any universal education program for adults that teaches skills to recognise potential domestic violence offenders.

At present DCP receives notifications and records these notifications on its data base. The Nyland report of 2016 indicates that DCP does not aim to investigate and substantiate all incidents when notifications are received, and does not routinely refer families to early prevention programs.

I understand the DCP data base has limitations that preclude the type of statistical analysis summarised above. I understand the DCP data base does not record specific risk factors and protective factors, and does not include a formula that sums risk and protective factors. DCP appear to interpret their primary role as being to wait until sufficient risks have been reported, and then to use their authority to remove children from parental care while they conduct extended investigations, rather than to facilitate delivery of preventive interventions or early intervention education or individualised rehabilitation therapies.

An adequate data system will include information about interventions that have been recommended to reduce risk. If the data base includes information about referrals for interventions, then the data base can be used to facilitate evaluation of efficacy of each intervention.

I consider that, to be effective and efficient, an adequate data system needs to be managed by statisticians.

Summary

This section outlined one scenario that leads to domestic violence that endangers mothers and children.

The section recommends the introduction of an evidence-based data system that records occurrence of substantiated risk factors and that can be used to categorize individuals into at least four levels of risk of becoming violent that are: no-risk / low-risk / medium-risk / high-risk.

It is recommended that an adequate data system will be managed by statisticians who are able to use data to make reliable predictions about a person's future behaviour, and to refer individuals to suitable intervention programs.

Data can potentially be entered by professionals from services such as the following: police, hospitals, health services, and teachers.

B - EARLY INTERVENTION

An early intervention system provides educational intervention for individuals who are identified as posing a low level of risk, when no harm has yet occurred. Early intervention is appropriate when an individual has been assessed as having some shortcomings and as likely to benefit from educational interventions. Referrals for early intervention might be recorded, but the decision by an individual to participate in early intervention is voluntary. Early interventions are usually brief universal preventive interventions that can be delivered to groups of individuals, rather than highly individualised interventions or prolonged interventions.

Q4 – Systems to record data about risk

Researchers have produced voluminous information about educational interventions to minimise use of methods of domestic violence. However, intervention methods have not been well categorised as suited for different stages of intervention such as prevention / early intervention / individual rehabilitation therapy.

To ensure efficiency of a classification system and to maximise coordination between service sectors, I propose a system that links **type of intervention** to levels of **assessed severity of risk,** where severity is assessed from impact on a person rather than likelihood of an event.

I propose the following five categories of severity of risk:

a. **No-risk** means no risk factors have been identified and no harm has occurred, so **universal interventions** that are available to all families are sufficient.
b. **Low-risk** means a few risk factors have been identified, with risk factors rated as having mild impact, and no harm has occurred, so referral to a voluntary **group early intervention** program is appropriate.
c. **Medium-risk** means that one severe risk or a number of risk factors are identified, there is risk of cumulative harm to a child or adult, or harm has been substantiated. A referral is made to an **individualised rehabilitation therapy** program that targets identified risk factors.

d. **High-risk** means that several risk factors are identified or some risk factors are rated as severe, and significant harm has occurred, and a referral is made to a **state-controlled** service that might restrict a parent's access with their child.
e. **Unacceptable risk** means that some risk factors pose an unacceptable risk of harm and legal orders are issued to **restrict ongoing access** between people.

To manage risk in this way, it is essential to move away from **subjective estimates** of risk that are based on information about anecdotes and hearsay to use of a more **objective assessment instrument** that is based on recording of substantiated risk factors and protective factors.

An assessment instrument for family violence should be constructed so that it is useful in three relevant courts: Magistrate's court, Family Law court, and Child Protection courts.

The approach to manage **different levels of risk** of domestic violence requires the following steps:

a. **Specific risk factors** that are associated with different likelihoods of domestic violence need to be identified that are **modifiable** variables, rather than unchangeable demographic variables that promote stereotypes.
b. The **probability** that each risk factor increases risk needs to be computed based on scientific studies.
c. **Level of impact** of a risk factor needs to be computed using about a **4-point scale of severity** such as: mild-impact / medium-impact / severe-impact / unacceptable-impact.
d. **Protective factors** need to be identified and quantified.
e. It is known that risk of harm increases as the number of risk factors increases producing cumulative harm, so a statistical procedure is required to **add probabilities** of harm associated with different risk factors and protective factors.
f. **Thresholds** need to be set to identify suitable interventions for each assessed level of risk, and reliability of predictions computed for each threshold.

The steps described above form a basic psychometric analysis that is used to validate an assessment instrument.

It is likely that preliminary data from international sources exist to make calculations about levels of risk associated with domestic violence. Once data are collected in a new system, statisticians can make ongoing refinements to their analyses.

Q5 – Permission for information to be used

Once individuals are assessed as posing differing levels of risk, a decision is required about who will be informed about the assessment. Principles of confidentiality and privacy become relevant.

Disclosure of information about risks

I propose the following principles about the disclosure of information about risk assessments:

a. When an individual is assessed as **low-risk**, only the individual is informed, and the individual is encouraged to participate voluntarily in a nominated early intervention program.

b. When an individual is assessed as posing a **medium-risk**, the individual is informed, and a referral is made to a designated program / provider.
c. When an individual is assessed as posing a **severe-risk or high-risk**, this information is passed to the individual and to a recommended program, and to other relevant authorities including courts.

Substantiate data

The following is required to ensure that data entered into an assessment framework are substantiated:

a. People who substantiate a risk factor and who enter data into a system are **qualified** to evaluate the data they enter.
b. Preferably data are collected using **structured instruments** that can be validated, rather than by recording only anecdotes.
c. A record is made of **who entered** specific data, and whether a data entry was amended.
d. A record is made of whether an allegation has been **substantiated**.
e. Periodic **audits** of data are made to assess whether assessors are reliable or exhibit any systematic bias.
f. Assessors are provided with regular **feedback** from audits about their assessments.
g. Assessors are educated about **legal standards** expected of an expert witness.

Q6 - Interventions to manage risks to victims & perpetrators

In the proposed format, distinctive words are required to describe each type of intervention.

Early intervention

Early intervention is provided when a risk factor has been identified in a case or is suspected but is not substantiated, and no injury has yet been caused.

Intervention programs for low-risk people are called **psycho-education**.

Individualised rehabilitation

An **individualised rehabilitation** program is provided when there is substantiated evidence that a person has been harmed, and the risk level is assessed as medium.

Interventions for medium level risks are called **individualised rehabilitation** programs.

Multiple and complex needs

Both the family law system (FCFC Federal Circuit and Family Court) and Child Protection system consider that it is common for several risk factors to occur in families where domestic violence occurs. These families are described as having '**multiple and complex needs**.'

The following risk factors for family violence and subsequent risk to a child's mental health are commonly cited: ongoing parental disputes; parent has difficulty managing their child's behaviour; parental substance misuse; separated parents dispute access to their child; parent

is isolated from family supports; parent experiences many stressors; previous notifications to DCP; allegations of child neglect; reports of domestic violence to police and convictions; and a child has significant special needs.

When a parent / family has multiple and complex needs then a decision is required about how to intervene. In my opinion, this becomes a matter for policy to be established jointly by State and Commonwealth Governments.

The topic of how to coordinate service delivery when a family has multiple and complex needs is discussed in section E about Coordination.

Proposal for making referrals

I make proposals about how individuals might be assigned to intervention packages.

A parent assessed as posing a **low-risk** might be referred to a provider who delivers an early intervention psycho-education service that is delivered in a group and that addresses an identified **primary risk factor**. For example, if a parent has a primary risk factor of experiencing difficulty in managing their child's disturbed behaviour, and is assessed as presenting with only low levels of other risk factors, then the parent might be referred to a parent education program.

If a parent is assessed as presenting **a medium-risk**, then the parent might be referred to a **specialist practitioner** who provides **individualised rehabilitation therapy** using a trans-diagnostic approach that addresses more than one risk factor, as discussed below in section D.

For example, if a child has been exposed to domestic violence and their parent has left the adult relationship and their protective parent is assessed as posing a low level of risk on other factors, then the child might remain in the care of their protective parent while **rehabilitation therapy** is provided that includes provision of joint parent-child therapy. A court might issue a **supervision order** for families where a parent is assessed as presenting a medium level of risk. The supervision order can state risk factors that need to be monitored and treated in **reportable therapy**.

Joint parent-child therapy is therapy that includes the protective parent, but does not include a parent who persistently offends.

If a parent is assessed as presenting a **severe-risk** of harm to a child, then it is recommended that the children be removed from the care of their parent, and the parent have supervised contact with their child. A parent who is assessed as presenting a severe-risk might be required to submit evidence of significant change before the parent is permitted to have unsupervised contact with their child.

In this proposal, levels of intervention and contact between a parent and child are matched to assessed levels of risk. Interventions that are more intrusive for a child and parent are not used as an initial intervention unless an objective assessment of risk indicates that the risk of harm is medium or high. Further, this proposal means that children who have been exposed to family violence are not exposed to a second unnecessary trauma by being removed from the care of a protective parent and from their family home.

This proposal gives a child the highest chance of receiving early intervention therapy and rehabilitation therapy that is targeted to meet the assessed needs of the child and family.

Based on these opinions, **I consider there is need for caution about a practice of seeking a court order to remove a child from parental care and to place the child into out-of-home care while prolonged investigations are made based on a suspicion and allegation that a parent used inappropriate childrearing practices during a crisis.**

Referrals by health services

It appears appropriate for health services to make an interim assessment of the level of risk a child is exposed to when there is initial evidence of family violence, and to make a referral to a suitable psycho-education service if a family is assessed as low-risk, or to an individualised rehabilitation therapy service if a parent is assessing as posing a medium-risk. It is appropriate for a health service to make a notification to DCP when a child is assessed as being at medium-risk or high-risk.

Summary

This section recommends that a data system be designed to refer individuals to a range of early intervention services when risk factors are identified, and not to wait until cases are assessed as being high-risk before considering therapeutic interventions.

It is proposed that a data system designed to refer individuals to suitable interventions will have the following features:

i. **Levels of risk** are assessed based on evidence about severity of impacts from known risk factors,
ii. Each level of risk is linked to **types of intervention**, based on the number and severity of risk factors, and presence of protective factors.
iii. **Thresholds** are set to improve reliability of appropriate referrals to services.
iv. **Criteria** are established to clarify **confidentiality** rules that apply to each assessed level of risk.
v. **Distinctive labels** are used to describe risk factors and interventions, especially therapeutic interventions.
vi. It is important to recognise use of **trans-diagnostic therapies.**
vii. It is important to provide joint **parent-child therapy** when domestic violence has occurred, where a protective parent is involved in the therapy.
viii. **Health professionals** can play a greater role in referring vulnerable families to psycho-education and therapy services, as well as making mandatory notifications to child protection authorities, to facilitate provision of early intervention therapy.
ix. **Child protection services** can refer vulnerable families to targeted therapy that is provided independently of the DCP if the data base shows that no referral has yet been made.

C – IMMEDIATE RESPONSE

Immediate Response describes the first reaction when a report about domestic violence is made to emergency services that include police, health services and the judicial system.

Q7 - Barriers to reporting

As discussed throughout this submission, there are a number of barriers that inhibit provision of coordinated delivery of protective services and therapy for families when an incident of family violence is reported.

Child protection legislation requires health professionals to make a mandatory notification to the Department for Child Protection (DCP) when they observe **any risk factor** for maltreatment of a child**. The mandatory notification system appears to divert the attention of health professionals away from referring vulnerable children and protective parents to early intervention therapies.** Perhaps health professionals erroneously believe that making a notification will increase chances that a vulnerable family will receive therapy that is targeted to address the identified risk factor and that is provided by a skilled and independent clinician.

One barrier to reporting is that many members of the public including health professionals are poorly informed both about effective therapy interventions, and about how to access effective therapy interventions. This is especially the case when interventions involve delivery of mental health services.

A further barrier to reporting to the DCP system is that notifiers receive no feedback about the outcome of their notification, so they are unsure whether their notification has added value for a child at risk.

Operations of the child protection system are important when domestic abuse occurs in a family, as, if a mother remains for too long in an abusive relationship, DCP staff are likely to conclude that the mother was not sufficiently protective, and DCP is likely to remove the child from parental care while they conduct lengthy investigations.

Q8 - Elements of best practice

In my opinion best practice for an immediate response to a report of domestic violence involves the following:

a. Identify the **number of risk factors** in a family using an assessment instrument that is structured and validated, rather than rely on anecdotes and hearsay information.
b. Assess level of **severity of impact** from each identified risk factor in a family, to identify families where there is a risk of cumulative harm to a child.
c. Use a scale of **severity of impact** with about 4 points, such as: mild-impact / moderate-impact / severe-impact / unacceptable harm.
d. Adopt the **National Framework for Protecting Australia's Children** 2009 that distinguishes four categories of parenting for policy purposes: *Capable parents* receive **universal supports**; *Vulnerable children* receive **early intervention** supports while in

the care of a protective parent; *At-risk* children receive **individualised rehabilitation therapy**; and *Unfit parents* have legally **restricted access** to their child.

e. Identify **evidence-based interventions** for vulnerable families that are **most effective** for each risk level, are least intrusive, and are cost-effective.
f. Use **names to describe interventions** that are understood by all participants.
g. Focus on **modifiable risk factors** that involve low- to medium-risk of harm to a child, where risk factors can be changed through brief targeted therapy, rather than on demographic factors that cannot be changed.
h. Instead of removing a child from parental care in families who are assessed as posing a low-risk or medium-risk while a **prolonged investigation** is conducted to assess whether a concern can be substantiated, record that a parent has been **referred** to a suitable early intervention service as a voluntary client on a basis of suspicion only.
i. Identify **accredited clinicians** who are capable of providing each type of intervention for each level of risk.
j. Ensure that delivery of interventions is **funded** by either the State or Commonwealth Government.
k. Require accredited clinicians who provide interventions for medium and high-risk clients to provide **reportable therapy interventions** to an identified authority as required, to facilitate overall accountability.
l. Offer education to accredited clinicians about **legal principles** for writing reports to courts.

There is a common misconception that **mental health diagnoses** are an accurate predictor of **future maltreatment of children** including of domestic violence. However, studies show that, while there are associations between parental mental diagnoses and **inadequate parenting**, the probability that a parent with a diagnosed mental disorder will harm their child is usually below a probability of 0.5, and evidence of a mental diagnosis alone does not meet the legal threshold of being 'on the balance of probabilities.' The risk factor of parental mental illness does become important when other risk factors are added, as the risk of **cumulative harm** to a child increases (Tustin d, in press).

One approach to provide a more accurate assessment of risk to a child is based on an assessment of **family dynamics** by conducting observations of **parent-child interactions** in structured situations to identify any inadequate parenting practices (Wilson et al, 2008; Garber, in press).

A second approach to assess risk to a child is to assess the number of critical **adverse events** a child has been exposed to. A report by Baidawi and Sheehan (2019) reported indicators that children notified to DCP might become crossover children who become involved in criminal offending. Two indicators that predicted likelihood of offending against people were: a stay in out-of-home care; and exposure to over 5 critical adverse events during their childhood.

Q8a – Interventions for Adult Victim-survivors

Appendix 2 provides a review of literature about evidence-based interventions to assist adults who have experienced domestic violence to recover from trauma.

The review by Karakurt et al (2022) demonstrated that provision of therapy that is targeted and individualised produces very significant improvements in a victim's stress management skills, reduces anxiety and depression, improves self-esteem, improves skills in preventing violence, improves safety, and improves social support. In most studies, therapies were provided by masters trained practitioners. The number of therapy sessions was not provided.

Best practice for an immediate response when an incident of domestic violence is reported includes:

a. A medical assessment is conducted to assess level of harm to the adult,
b. A report is made to police, and consideration is given to issuing an apprehensive of violence protection order,
c. An assessment is made of the presence of other risk factors, using a structured scale that has been (or is capable of being) validated,
d. Victims are referred to a therapeutic intervention that is appropriate for the assessed level of risk to promote their recover from potential trauma.

Q8b – Therapy for Child Victim-survivors

McFarlane (2017) conducted a review of 160 files of children who had been in out-of-home (OOH) care and who progressed to being charged with crime, called 'crossover children.' McFarlane found the rate of crime was higher for this cohort of children who had an OOH history. McFarlane concluded that the cohort of OOH children who progressed to committing crimes had lived in an environment that was designed to protect them from harm, but the environment had contributed to criminalising them.

Baidawi and Sheehan (2019) studied files of 300 children in Victoria who had been notified to DCP and had appeared in a Magistrate's court, showing a trajectory from child protection to the criminal justice system. The study found that 73% of the crossover children had been exposed to family violence, and 86% of offences involved offences against a person. 80% of the sample had spent time in out-of-home care as a child. They assessed the children's exposure to childhood adverse events and found that crossover children had been exposed to a mean of 5.4 adverse childhood events. The writers concluded that there were indicators to identify crossover children before the age of 10 years, and to refer the vulnerable children to preventive intervention services instead of waiting until the child's behaviour attracted criminal sanctions. The study noted that crossover children were charged with very high rates of offending, with one study finding that offenders committed 77 offences each.

The question of who makes decisions about therapy for children who have been exposed to family violence becomes important. If a child is removed from parental care while DCP conducts extended investigations, then decisions about therapy provided for the child are made by DCP staff. It is not clear that DCP staff consistently decide to provide effective evidence-based therapies.

Appendix 3 provides a review of literature about evidence-based interventions that have been shown to minimise risk of ongoing trauma in children who have been exposed to domestic violence and other stressors. Important findings are summarised:

a. Therapy is most effective when it **targets risk factors**, and effective therapies for traumatised children can be delivered in about 16-21 sessions (Bartlett et al, 2018).

b. A review of 21 studies by Dorsey et al (2017) of psychological therapy for children who had been exposed to trauma found that effective therapy had **seven components**: Psycho-education about trauma prevalence, impact and the intervention; teaching emotional regulation strategies of relaxation, labelling emotions, and cognitive coping; imaginal exposure to the traumatic event; in vivo exposure to safe situations; cognitive processing; problem solving about critical situations; and involvement of a protective parent if a child is aged 3-6 years, a child displays disturbed behaviour and the involved parent has anxiety and/or depression.
c. A review of therapies for children by Romano et al (2021) found an **effect size** of d=0.49 for children who displayed internalising disorders, and an effect size of d=0.36 for children who displayed externalising disorders.
d. Szota et al (2023) conducted a meta-analysis of 33 studies where parents had been involved in joint parent-child therapy and found the following **effect sizes**: d-0.34 for effects reported by children; and d=0.41 for effects reported by parents.
e. When a family has several needs, it is important to provide **individualised therapy**.
f. A range of effective therapies have been identified (Xiang et al, 2021), and it is best to leave **selection of therapies** for each family to an accredited therapist to ensure that therapies are individualised to meet the needs of each family.
g. Using **multiple providers** who have unclear roles introduces a significant risk of re-traumatising a child who has to repeat their story of trauma to many providers (Ko et al, 2008).
h. As it is difficult to coordinate therapies when several providers / agencies are involved, it is important to consider referring families who are assessed as posing a medium-risk of harm to **one therapist** who is qualified to provide a **trans-diagnostic therapeutic approach** (Ko et al, 2008). A clinician who provides trans-diagnostic therapy addresses risk factors rather than mental health diagnoses.
i. There is value in having therapy provided by skilled clinicians who operate **independently of welfare services** (Ko et al, 2008).
j. Greenberg et al (2012) reported that **effective components for joint parent-child therapy** include: focus on parenting practices; protect a child from unreasonable hazards; clarify how each parent perceives difficulties; encourage a child to act in pro-social ways in challenging situations; establish boundaries a family will respect; state boundaries in terms of specific behaviours rather than character traits; encourage a distressed child to express their feelings using words; that are acceptable in the family and in society; encourage the child to identify triggers that set off their feelings; clarify routines that promote acceptable behaviour; encourage all family members to avoid behaviour that distresses other family members; identify goals and behaviours that help to achieve goals; identify discrete situations associated with tension and clarify appropriate behaviour to manage these challenges; use methods of positive discipline and minimise use of punishment with a distressed child; use safe natural consequences of behaviour, and minimise use of arbitrary restrictions on pleasurable activities unrelated to misbehaviour; encourage parents to apologise when they make mistakes with their child; encourage parents to be a good role model for their child; and avoid blaming the other parent for a child's misbehaviour;.

Best practice for children who have witnessed domestic violence or have been subjected to domestic violence includes:

a. A medical assessment is conducted, with consideration to referring the child either for individual brief therapy or for joint parent-child therapy with a non-offending parent.
b. Consideration is given to making a report to police.
c. The medical examiner makes a judgment about whether a notification to child protection is warranted, based on guidelines provided.
d. The medical examiner refers a family to appropriate early intervention therapy.

Protocols for police

Ko et al (2008) report that many Police Departments have established protocols for investigation, reports to Child Protective Services, forensic interviewing, and access to medical and psychological intervention. They cite the Child Development Community Policing (CD-CP) program as a model program for creating trauma-informed police systems.

Ko et al (2008) describe principles used in a National Child Welfare Trauma Training Toolkit that identifies essential elements in trauma-informed practice for children to include: (a) maximize the child's sense of safety; (b) help children to reduce their overwhelming emotions; (c) help children to give new meaning of their trauma history and current experiences; (d) use comprehensive instruments to assess the child's trauma experiences and their impact on the child's development and behaviour and relationships to guide selection of intervention services; (e) support and promote positive and stable relationships in the life of the child; (f) provide support and guidance for the child's protective family and caregivers; and (g) coordinate service delivery.

Training of generic health professionals

Ko et al (2008) consider that most generic health care personnel employed in hospital emergency departments have received minimal training in trauma-informed approaches. They opine that many health practitioners limit their trauma-related role to identifying and reporting suspected child abuse or maltreatment. Ko et al note there are opportunities to promote an integration of trauma-focused practices that includes referral for mental health treatment and for other support services, as well as referral to protective services. Tasks they identify as important in an integrated system include: provide accurate risk detection and case identification; triage clients to receive appropriate interventions; ensure continuity of care between providers; facilitate staged flexible multisystemic interventions for high-risk populations; and a need for interdisciplinary collaboration.

Ko et al recommend that programs that are designed to provide trauma-informed care for children need to be continuously and rigorously monitored and evaluated to ensure that the programs actually benefit children and families.

Voice of the child

The Australian Government in 2011 introduced National Standards for Out-of-home care (OOOH care). Standard 2 states, ‘Children and young people participate in decisions that have an impact on their lives.’

The Australian Institute of Health and Welfare reports on indicators that each standard is being met. The AIHW Child Protection Collection 2021–22 contains no information to indicate that Standard 2 of the National Standards for Out-of-home care is being met.

While the South Australian Government amended its child protection legislation following the Royal Commission report in 2016, and produce the Children's and Young Person's Safety (CYPS) Act in 2017, principles from the National Standards for Out-of-home care appear not to be mentioned in the CYPS Act. One consequence of excluding Standard 2 from the National Standards from the CYPS Act is that the Youth Court is unable to assess how well children are consulted about proposals for a child to be placed into DCP care until they reach the age of 18 years.

Investigative journalist McLachlan (2023, page 37) suggests that the principle of courts hearing the child's voice is often not implemented in South Australian courts. McLachlan noted that lawyers who represent the interests of children in the Youth Court (Independent Children's Lawyers, ICLs) are not required to speak to the child they represent (pages 37, 121).

A related issue is that legislation has not yet identified an **age when young people** are viewed as being mature minors who are capable of making their own decisions, and of addressing courts directly, beyond the generic proposal that young people lack legal capacity until they reach the age of 18 years.

McLachlan discusses dilemmas that arise when a mother believes their child has been subjected to sexual abuse (page 98). McLachlan reports that mothers who report that their child has been sexually abused might face allegations that they were not sufficiently protective towards their child (page 53), or that they did not report their concern to police (page 45), or that they encouraged their child to lie (page 55), or that they coached their child (page 99), or that they might be attempting to alienate the child from the other parent (page 55), or that their report demonstrates mental health symptoms of a delusion (page 98).

McLachlan (page 55) refers to instances when children who reported being maltreated were viewed as being liars.

McLachlan cites reports from parents that, if their child had been placed in a group home with other disturbed children and a protective parent enquired about an injury to their child they observed during a contact session, they might be criticised by a DCP worker for asking inappropriate questions, and for not focusing on their own parenting practices, and a threat may be made that their future contact time will be reduced (page 63).

McLachlan opines that, while a child's therapist can pass on information to a court about statements made by a child during therapy, courts might hold a view that the therapist displays a therapist bias, and that low weight will be given to evidence provided by a therapist (page 55).

Q8c – Perpetrator treatment

Appendix 4 provides a brief review of literature about treatment of perpetrators of domestic violence.

Reviewers are cautious about efficacy of treatment for offenders. No particular model of treatment has gained widespread acceptance amongst reviewers.

One review identified reporting offenders to police as an effective intervention (Bell & Coates, 2022).

Best practice when there is an allegation that an adult or teenager participated in domestic violence includes:

a. The allegation is referred to police for investigation.
b. The person is referred to a specialist behaviour change program.

Q8d – Treatment of families with complex needs

The Terms of Reference for the Royal Commission encourages enquiry into the complex causes of domestic violence and encourages recommendations that will facilitate widespread change in practices. This submission raises additional topics for consideration, over and above topics listed in the proforma.

As discussed above, some families where domestic violence occurs present with a number of risk factors, where risk actors have varying levels of impact. These families are described as having **multiple and complex needs**.

Treatable risk factors for maltreatment of children in families with multiple and complex needs include: couple tensions; parental mental health disorders; parental anger; and parental substance misuse.

Appendix 5 summarises research into efficacy of therapy interventions for families that have multiple and complex needs.

Conclusions from the literature are summarised.

Couple therapy

Appendix 5 provides an overview of couple therapies used in families where tensions between parents can escalate into family violence.

Reviewers conclude that couple therapy may be more effective when domestic violence occurs only in stressful situations, and is not a reflection of the personality style of one parent (Karakurt et al, 2016).

A model of therapy called Emotionally Focused Couple Therapy appears to be gaining favour (Spengler et al, 2024).

Parental mental illness

Research on efficacy of therapy for parents with a diagnosed mental disorders in improving their parenting capacity is reviewed in Appendix 5.

Researchers identify parental depression as a mental illness that requires monitoring and therapy that addresses both depression and potential impacts of depression on parenting practices. Psychological therapy for depression has been found to be effective in reducing maternal depression (Bee et al, 2014).

Home visits by therapists and use of video-feedback of a parent's own parenting behaviour are identified as effective interventions (Stewart-Brown & Schrader-McMillan, 2011).

Transmission of mental illnesses across generations may require coordinated therapies for a parent and child (Siegenthaler et al, 2012).

Parental substance misuse

Parental substance misuse is identified as a parental condition that has an adverse impact on the development of children.

The interventions of motivational interviewing (Burke et al, 2003; Lundahl et al, 2010) and Cognitive behaviour therapy (Magill et al, 2009) have been identified as effective in producing low to moderate effect sizes in reducing consumption of illicit substances.

The goal of intervention might be set at a parent being abstinent from substances for a period of at least one year.

Failure to provide therapy for children

In recent years a number of reports have appeared that provide information about failure to provide therapy for children who have been traumatised by incidents such as domestic violence. In particular, reports question that wisdom of continuing with an approach of relying solely on removing victimised children from parental care and placing the child into traditional foster care.

Impact of exposure to domestic violence

Wolfe et al (2003) conducted a meta-analysis of 41 studies of children who had been exposed to domestic violence, and found an association between exposure to domestic violence and a child having disturbed emotions and behavioural problems with an effect size of z=0.28. This finding indicates that a significant proportion of children exposed to domestic violence require therapy.

Breakdowns in foster care

Dozier (2002) reported that traditional foster care was associated with fostered children having difficulty in regulating their emotions and their behaviour, and difficulty in developing social skills.

Lawrence et al (2006) conducted a longitudinal study of 189 children in traditional foster care and found that these children showed an elevated level of behaviour problems compared to comparison groups, where the behaviour problems continued following release from care.

Vanschoonlandt et al (2012) conducted a study of the prevalence of externalizing behaviours of 212 fostered children in Flanders, and found that 40% of the children displayed externalizing behaviours. They called for use of standard protocols to assess occurrence of externalizing behaviours in fostered children to facilitate provision of appropriate therapy for these children.

Jacobsen et al (2020) confirmed that fostered children become at risk of being less well-adjusted in their social and emotional functioning, and reported that there was no consistent evidence that their functioning improved from being placed in foster care, with externalizing behaviour being linked to disruptions of placements. Their study found that a child's behavioural disturbance in foster care at age 2-3 year predicted the child's continued behaviour problems at age 8 years.

Oosterman et al (2007) reviewed studies of 20,650 children who had been placed in foster care, and examined factors that were associated with breakdowns in foster care. They found that 12 studies identified children's externalising behaviour problems as being linked to breakdowns in traditional foster care, and identified children's externalizing behaviour as a robust predictor of a breakdown.

Jones and Morris (2012) examined the phenomenon of children in foster care having multiple placements and found that multiple placements were associated with foster carers having difficulty managing children's behaviour.

A study by Octoman et al (2013) of 200 fostered children in South Australia found that one cohort of children that carers found difficult to manage were children who displayed externalizing behaviours including being aggressive, controlling and enjoying upsetting others.

West et al (2023) cited research that foster carers who found the behaviour of a fostered child difficult to manage were inclined to become more detached from the child, be less supportive, and use more authoritarian child-rearing methods; a strategy that results in children displaying more problematic behaviour and to breakdowns in placements.

Goemans et al (2015, 2016, 2018) reported a series of studies of fostered children in Holland. Goemans (2015) conducted a meta-analysis of studies, and reported that 21 studies found that fostered children displayed externalizing behaviours, and found that length of time in foster care did not change frequency of externalizing behaviours. Goemans et al (2016) examined 446 fostered children in Holland and found that children with externalizing behaviours on entry continued to display these behaviours during their time in care. Goemans et al concluded that children with externalizing behaviours require careful assessment and intervention. Goemans et al (2018) followed up 237 fostered children in Holland over a mean period of 4.6 years and found that parenting provided by traditional foster carers was not effective in changing children's internalizing or externalizing behaviours, indicating that foster carers require additional support to read disturbed children.

Ward (2009) confirmed that multiple placements in foster homes in the UK were associated with poor outcomes and found that most changes in placement were transitions that were planned by case managers. Dorsey (2008) explained that traditional foster care had three roles of: promoting reunification; or a carer became a guardian; or a carer provided short term care until a child transitioned to a permanent guardian through adoption.

Cheung et al (2011) followed up 1063 fostered children in Canada and assigned variance in externalizing behaviours to three sources: child, foster carer, and case manager. They found that 72% of variance for externalizing behaviour could be attributed to child-specific factors; 18% of variance was attributed to faster carers; and 10% of variance was attributed to case management practices.

A number of researchers have identified children in foster care whose behaviour is difficult to manage as displaying externalizing behaviour as well as trauma-related behaviour (Becker & Kerig, 2011; Perry & Price, 2018; Northam & Dadds, 2020; Pasalich et al., 2023; Kimonis, 2023; Streicher et al, 2023).

Becker and Kerig (2011) assessed 83 youths who had been detained in a juvenile justice system, and found that 95% had experienced trauma, and 20% met full criteria for a diagnosis of PTSD.

A meta-analysis of interventions for children who displayed externalizing behaviours was reported by Baumel et al (2021) who analysed 111 randomised control trial involving 11.623 children. They found that interventions with children whose symptoms were in the clinical range were effective with an effect size of g=0.38, and that efficacy was sustained at follow-up with g=0.27. They found the most effective interventions involved both a carer and child, with an effect size of g=1.11.

A further meta-analysis was conducted by Jugosav et al (2022) involving 43 studies. They found interventions that focused on children's attachment bonds and emotional development were effective in reducing externalizing and internalizing behaviours, and that efficacy was sustained during follow-ups of 6 months and longer.

A study by Dixon et al (2009) asked 103 health visitors to assess parenting styles and risk actors in 4351 families after birth. Their study distinguished families who did and didn't change their maladaptive parenting practices. A group of parents they called 'cycle breakers' were distinguished as they had supportive factors of receiving social support and being financially solvent.

Q8e – Child protection system

I consider it important to include additional topics in the Commission's scope.

This section addresses practices of the Department of Child Protection (DCP) as health professions are required to make mandatory notifications to DCP if a parent presents with indicators that domestic violence might occur in a household. I submit that **only** making a mandatory notification places some children on a **trajectory that is significantly disadvantageous for children.**

Indicators used by hospitals that domestic violence might occur in a family include: a mother is emotionally distressed and might experience a mental disorder; a child has an injury that might have occurred non-accidentally; and a mother presents with other risk factors.

Controversial practices of DCP since the implementation of the Children's and Young People's Safety Act 2017 (CYPS, 2017) have been summarised in a recent book by investigative journalist Dee McLachlan (2023), entitled 'The child protection racket.'

McLachlan reports that the common experience of children and families when a health professional makes a notification to DCP based on a *suspicion* that a child *might* be at risk of harm due to risk factors in a family is as follows:

a. DCP might investigate the allegation of domestic violence to substantiate the allegation, or DCP might defer an investigation until several notifications have been received.
b. If DCP decides to investigate, DCP is likely to seek an order for the child to be removed from parental care for a period of about 3 months while a more thorough investigation is conducted.
c. A DCP investigation focuses on whether the child has been harmed or is likely to be harmed, rather than on providing therapy for the child.
d. A DCP investigation might focus on whether there are risk factors indicating an increased chance that a child could be harmed, rather than on seeking evidence that a child has experienced actual harm.

e. A DCP investigation might focus on whether a child has experienced poorly defined emotional abuse.
f. DCP investigates whether the non-offending parent was sufficiently protective of their child, and DCP commonly restricts contact between the child and parent to supervised contact while their investigation proceeds.
g. DCP is slow to recognise that restricting contact between a child and their parent might itself traumatise and harm a child who has developed an attachment bond with their parent.
h. If the non-offending parent displays high levels of emotion while in the presence of their child, DCP is likely to conclude that the parent's distress reflects an emotional disorder or an unresolved trauma from the parent's past.
i. DCP does not routinely refer distressed parents for therapy, as their focus is on the welfare of the child.
j. If DCP considers the parent might have a mental disorder, then they apply for an extended order for the child to remain in out-of-home care while they continue their investigation.
k. DCP might refer a protective parent to a departmental mental health professional who conducts assessments on behalf of the department, introducing a possibility of investigator bias rather than providing an independent and impartial assessment.
l. If a mental health professional does not confirm that a parent has a mental disorder, then DCP might proceed to identify alternative reasons why a child should not be returned to the care of their parent. Alternative reasons include: a parent uses parenting methods that are not approved of; a parent remained for too long in a relationship involving domestic violence; a parent has a past history of being admitted to a hospital emergency department in a distressed state and was given a provisional mental health diagnosis; a parent has a past history of misusing substances; a parent lacks support in their parenting role; and a parent is exposed to multiple stressors.

DCP might require a parent to participate in in-home contact sessions with their child that are supervised by workers who are funded by the department and who report back to the department. Parents are often apprehensive that workers who are funded by the department who is prosecuting them might focus of looking for further evidence that they maltreat their child, rather than on delivering an evidence-based parent education program (Nyland, 2016).

It is proposed that a better practice for health practitioners is make an initial assessment of the level of risk to a child, and to refer a family for early intervention therapy concurrently with making a notification. It is proposed that families assessed as posing a low-risk or medium-risk can remain intact while early intervention therapy occurs so that joint parent-child therapy can be provided.

Q8f – Legislation about parental rights

I consider it necessary to include the topic of legislation about the rights of parents and children in the scope of the Commission.

The Australian Government in 2011 issued two policy statements:

- National Standards for out-of-home care, and
- National Clinical Assessment Framework.

National Standards for out-of-home care

Two standards from the National Standards for OOH care appear relevant when a child has been exposed to family violence:

- Standard 2 states, "Children and young people participate in decisions that have an impact on their lives"
- Standard 5 states "Children and young people have their physical, developmental, psychological and mental health needs assessed and attended to in a timely manner."

As discussed above under Question 8b, the Australian Institute of Health and Welfare has not been able to achieve agreement between states about an indicator to measure how well Standard 2 is being achieved.

The Australian Department of Health in 2011 issued a policy statement called National Clinical Assessment Framework. The Clinical Assessment Framework proposes clear criteria including: a preliminary health check when a child enters OOH care; a comprehensive health and developmental assessment within 3 months of placement; further assessments according to the needs of individual children; development of a health management plan; follow-up monitoring to ensure that issues are being appropriately addressed; and creation of a nominated position of Care Coordinator Health to ensure that referrals are made to specialist services.

Recommendations

This submission recommends that principles from the National Clinical Assessment Framework be introduced in an amended CYPS Act.

McLachlan (2023, page 80) notes that the current CYPS child protection legislation gives responsibilities to parents, but does not recognise any parental rights. Not having any parental rights becomes a significant restriction for parents who are exposed to family violence, when their own child begins to imitate the violence and either becomes aggressive towards others or engages in self-harming behaviour.

I recommend there is a need for amended legislation to address three topics:

i. Intervention methods that are viewed as '**therapeutic touch'** that parents are entitled to use to manage the behaviour of disturbed children.
ii. To **authorise parents to give permission** for therapists to use therapeutic touch, especially when a therapist provides in-home parenting coaching for children who engage in externalising / acting-out behaviours.
iii. To identify the below which parents are authorised to make decisions about use of therapeutic touch, and the age when young people are authorised to make their own decision about legal topics that arise.

i – Therapeutic touch

Most therapists have been taught that people have a right to body integrity, and that other people may touch them only with their explicit consent. Therapists are taught that any unauthorised touch is assault.

There is a professional literature that distinguishes between types of touch that are assault and illegal, from other types of touch that are beneficial for children and should be recognised as therapeutic touch (McParlin et al, 2023; Garrett, 2021). Kemper and Kelly (2004) report that therapeutic touch assists in the treatment of anxiety in children and is widely used in paediatric hospitals.

Types of touch that might be considered as therapeutic touch and that are appropriate to be used by parents and carers and therapists include:

a. Soothing touch, where an adult hugs a distressed child to calm the child,
b. Physical guidance, where an adult gently guides a child's limbs when the child does not resist the pressure,
c. Physical restraint, where an adult briefly applies a low degree of force to a child's limb to prevent a child from acting in a way that is aggressive to others or produces self-harm,
d. Blocking, where an adult stands in the path of a child to prevent the child from running into an area that is dangerous,
e. Affectionate touch on a 'public' (not private) part of the body such as a shoulder or hand to show affection and friendliness.

Therapeutic touch is used more by carers both when a child has a disability, and when a child exhibits oppositional behaviour / conduct disordered behaviour (Field et al, 1997). Sorvoll et al (2022) report that touch therapy assists the development of children's sensori-motor skills. Now that children with these mental health conditions are in mainstream services, it is timely for legislation to distinguish between physical interventions that are viewed as being therapeutic, and physical interventions that are viewed as assault.

It is proposed that an explicit definition of therapeutic touch will reduce the apprehension of parents about being accused of assaulting their child or emotionally abusing their child and will clarify parenting practices that are viewed as legal and can be endorsed.

A legal definition of therapeutic touch will help to distinguish therapeutic touch from grooming.

ii – Authorise parents to use touch interventions

It is proposed that legislation be passed to state explicitly that custodial parents have the right to use therapeutic touch with a child in their custody. Passing this legislation would significantly increase the confidence of parents about interventions they are permitted to use in raising their child without being accused of assaulting or grooming their child.

iii – Age for young person to consent

A further step is for legislation to explicitly authorise parents to give authority to a carer / therapist who provides an in-home parent coaching service to use therapeutic touch as part of a behaviour management program for their child.

Q9 – Best practice health response

The information provided in appendices shows that mental health researchers have identified a wide range of evidence-based interventions that are highly relevant for improving parenting practices in families where children are vulnerable from being exposed to adverse conditions including domestic violence.

The Australian Government in 2022 introduced a National Children's Mental Health and Wellbeing Strategy that emphasises the need for children in vulnerable family contexts to have improved access to evidence-based therapies. The Strategy identifies children whose parents are involved in child protection courts as being at increased of being maltreated and developing a mental disorder, and as requiring appropriate therapy.

This submission proposes that it is viable to introduce a system where therapists are accredited to provide evidence-based and evidence-informed interventions. It is proposed that children in vulnerable family contexts be referred to an accredited therapist, and for the therapist to select therapy interventions that are relevant for each family.

It is recommended that accredited therapists come from a multi-disciplinary background.

The following proposals are made:

a. When making a notification to DCP, a health professional should record that they have also referred a family member to a named therapist or therapy service.
b. Accredited therapists who treat a family should make a further notification if they detect additional risk factors that were not identified in the first notification. A therapist who is treating a known risk factor does not need to make repeated notifications for a condition they are treating.

The best practice response from a health service when they detect a risk factor that a client might be subjected to family abuse is to refer relevant victims to appropriate physical and mental health therapy services.

Q10 – Best practice police response

This question is answered with the benefit of a literature review.

The best practice police response when an allegation is made about domestic violence or sexual abuse appears to include:

a. Interview the complainant.
b. Inform the alleged perpetrator that an allegation has been made.
c. Consider need for an intervention order.
d. Clarify whether the complaint wishes to press charges.
e. Assess people's immediate safety and the need for a person to be relocated.
f. Ensure a high standard of documentation.
g. Notify other services as per protocols.

Q11 - Best practice judicial responses

The Commonwealth Government in 2022 issued a policy 'National Children's Mental Health and Wellbeing Strategy.' The National Strategy identifies cohorts of children who are at increased risk of developing a mental disorder and this includes two cohorts of children whose parents become involved in proceedings in family-oriented courts. One cohort involves children whose parent has been diagnosed with a mental illness. A second cohort involves children where notifications are made to a child protection service based on a suspicion of maltreatment.

The National Strategy recommends that families where children are vulnerable received increased access to therapy. Tustin (c, in press) summarises scientific findings about parenting practices associated with specific parental mental disorders that increase vulnerability of children. It is viable to provide individualised therapy to change inadequate parenting practices. However, there are many barriers at the judicial level that interfere with registered clinicians providing evidence-based therapies for children in vulnerable families.

Investigative journalist Dee McLachlan (2023) published a book about current operations of the judicial system in South Australia following the implementation of the Children's and Young Person's Safet Act (2017). Concerns raised by McLachlan and others are summarised below, together with other concerns.

a - Authority of Youth Court

McLachlan (2023) makes a number of allegations about functioning of DCP in South Australia. McLachlan (page 92) notes that once the Youth Court has made an order, the court has no authority to monitor the welfare of a child the court has placed into departmental care. DCP rarely applies for supervision orders that can be authorised under the CYPS Act.

McLachlan makes a number of specific allegations about malfunctioning of the DCP system in South Australia, as follows:

i. DCP and the Youth Court follow a high level of confidentiality. McLachlan uses the word 'secrecy' as there is very limited disclosure of information on topics such as thresholds used when decisions are made to remove children from parental care, supposedly to protect the confidentiality of the child (page 31). A contrast can be drawn with the transparence of FCFCoA who publish de-identified summaries of rulings on a website AustLii.

ii. The boundary between topics that are addressed by FCFCoA and by the Youth Court is unclear (page 113), and this can lead to both courts being involved in a case, and it can result in the two courts making contrary orders.

iii. While DCP has policies, there is doubt that all regions follow these policies, resulting in some regions receiving more criticism than other regions (page 59).

iv. DCP employs primarily staff trained in one discipline, rather than having multi-disciplinary workforce (page 79).

v. The rate of removing Aboriginal children from care of their parents is very high (page 79).

vi. It appears that DCP staff have been authorised to view confidential records made by health professions employed in the state's hospitals, leading to DCP citing health records inappropriately (page 114).

vii. DCP emphasises removal of children rather than providing early intervention therapy to improve a parent's inadequate parenting skills (page 50).

viii. There is little evidence that removing notified children from parental care using a low threshold is effective in improving a child's mental health (page 31). DCP often cites the fact that a new mother was a previous client as evidence that the new mother has not learned an adequate parenting template.

ix. DCP appears reluctant to change their assessments of a parent even if new information is provided, and the rate of reunification of removed children with their parent is reportedly low (page 50). McLachlan interpreted DCP policy as being a 'No return' policy (page 94).

x. Lawyers who work in the child protection system have become acclimatised to the routine removal of children (page 35).

xi. DCP is very well resourced compared to the Youth Court and to parents, resulting in the Youth Court being reliant on assessments provided by staff employed by or funded by DCP (pages, 34-35, 92).

xii. There is a perception that the Youth Court might 'rubber stamp' submissions made by DCP (pages 34, 92).

xiii. Assessors who provide reports to the Youth Court are not independent of DCP (page 35). McLachlan describe assessors as 'write reports to order' (page 35). Further, assessors commonly express opinions without using validated assessment instruments, so it is difficult to view their assessments as being objective (page 35). It is not clear that reports submitted by assessors are balanced by reporting information about a parent's strengths as well as a parent's deficiencies.

xiv. An assessor might comment about how long it will take for a parent to demonstrate sufficient skills for reunification to be viable, although the assessor has no experience in providing reunification therapy (page 48).

xv. Departmental staff make allegations that a parent has or might have a mental disorder, although staff lack qualifications to make these diagnoses (page 98).

xvi. DCP staff continue to raise concerns about a parent having a diagnosed mental disorder even after their concern has been discounted by a relevant professional (page 48).

xvii. When DCP workers make allegations that a parent has a mental disorder, there is little evidence that the worker refers the parent for therapy (page 49).

xviii. DCP staff follow a practice of withholding children from contact with their child, and requiring limited supervised contact for many months, to see if a protective parent will 'break' (page 49).

xix. If a mother shows emotional distress when contact with their child ends, DCP might describe the mother as being 'emotionally unstable' and might accuse the mother of encouraging their child to become disruptive (page 64).

xx. DCP refer to the poorly defined concept of emotional abuse of children on the basis of anecdotal information, and DCP does not use any established assessment instrument to assess the concept of emotional abuse (page 79).

xxi. DCP staff go through a list of possible concerns in sequence, so if one concern is not substantiated, then they raise another concern from their list (pages 105-6).

xxii. If a child is placed into temporary foster care on a short-term order, DCP staff might discourage the carer from showing affection towards the child as the child might form an attachment with the carer and then become distressed if DCP decide to place the child with another carer (pages 81-2).

xxiii. In many cases DCP workers do not substantiate allegations about parents. Instead, allegations are recorded in a departmental file which is then passed from one worker to the next

worker, where workers repeat written information and function like a cartel (pages 33, 94). An alternative approach is for DCP to assess each parent's parenting capacity using a structured instrument that can be validated.

xxiv. Placing a child into foster care until the age of 18 years is costly compared to the cost of providing early intervention therapy to support a protective parent (page 83).

xxv. McLachlan (page 35) notes that the Youth Court lacks the capacity to make its own independent investigations, introducing a possibility that the court 'rubber stamps' proposals it receives from DCP.

xxvi. McLachlan further notes that, under the current CYPS Act, once an order has been made to place a child into DCP care, the Youth Court has no further authority over care of the child.

The concerns raised by McLachlan (2023) were not addressed in the review of DCP commissioned by the South Australian Government following the deaths of children that was provided by Alexander and McCulloch (2022). Alexander and McCulloch reported there have been 811 previous recommendations about changes in DCP (page 6).

b - CYPS Act 2017

The CYPS Act (2017) requires mental health clinicians who provide therapy for vulnerable children to provide confidential information to DCP on request. Commonly, DCP write to a therapist identifying reasonable and specific questions where they seek information. The letters commonly give therapists 21 days to provide the requested information. The DCP proforma letter points out that information gained may be used in court proceedings.

Letters sent by DCP to therapists commonly include a reference to section 150(5) of the CYPS Act indicating that a failure to comply with the notice is an offence and leaves the therapist liable to a period of imprisonment of up to one year.

Many therapists are deterred from providing therapy for children who might become involved in proceedings in the Youth Court due to the threat of prosecution if a therapist does not comply with passing on confidential clinical information to the department.

c – Use of Subpoenas

The FCFCoA is able to issue a subpoena that requires a mental health clinician both to produce copies of confidential client information held in clinical files, and to give evidence in court.

FCFCoA has issued an Information Sheet about subpoenas. The Information Sheet indicates that a clinician may object to producing a subpoenaed document on three grounds: (a) a document requested is irrelevant; (b) a document is privileged as it came into existence as a result of a special relationship; and (c) the terms of the subpoena are too broad.

A practice of some barristers of seeking a subpoena for a 'full file' introduces dilemmas for clinicians in circumstances where a client has shown a 'lack of filter' and has provided their clinician with superfluous information, including information that was sourced from third parties and that are not addressed to the clinician. Clinicians are concerned that, if they make an unauthorised release of confidential information that was not addressed to them, then they

may be liable to have legal action taken against them under Australia's Privacy Act if the released information is used to harm the originator of the information.

A second concern arises when a subpoena is stated in very broad terms. Clinicians are concerned that one party might seek a subpoena as part of a 'fishing expedition' where an allegation has been made without evidence, and the purpose of the subpoena is to find some grounds to substantiate an allegation. A clinician might hold a concern that many expectations of barristers about how clinicians should practice are not written in a Code of Practice for Clinicians, and if a clinician did not practice according to an unwritten idea held by a barrister, then a notification could be made to the professional registration body AHPRA, resulting in an arduous and lengthy investigation, and to an increase in their insurance premium.

Many clinicians are concerned that the lack of a Code of Practice for Clinicians who provide therapy for court-involved clients leaves them vulnerable to various forms of adversity. Some clinicians feel they are put on trial themselves when they give evidence in a family-oriented court to assist the court.

I make the following recommendations:

i. That the Commission encourage appropriate authorities to develop a **Code of Practice** for mental health clinicians who provide therapy for members of vulnerable families, covering the topics of how to keep records and how to write reports for family-oriented courts.
ii. That a Code of Practice provide recommendations about how a clinician might keep records in ways that are compatible with expectations of courts that issue subpoenas.

I propose that best practice principles for judicial officers include:

i. If a mental health clinician who has provided therapy for a vulnerable member of a family, then the clinician be asked to provide clear information about their expertise.
ii. That a barrister who seeks information from a clinician write to the clinician asking the clinician to answer specific questions and undertaking to pay the cost of the report.
iii. That subpoenas be used only if a clinician fails to respond adequately to a written request for information.
iv. Feedback is provided by the court to each expert witnesses about the quality of their evidence in assisting the court on the topics being resolved by the court, to enhance the quality of future report writing.
v. That courts acknowledge that it is a role of an expert to update the court about advances in a field of study that is relevant to the case.

e - Reversed burden of proof

The current CYPS Act (2017) require DCP to submit evidence to the Youth Court if its investigations find evidence of risk factors indicating that a child might be at risk of harm. DCP can provide evidence about the existence of risk factors in a family, without providing evidence that a child has actually been harmed.

One difficulty with the approach of submitting evidence only about the existence of risk factors, is there is no agreed formula to add impacts of various risk factors and protective factors, and to

reach a final assessment of level of risk to a child. Many researchers have reported that certain risk factors increase risk to a child, without quantifying the level of risk posed by each risk factor.

Once the Youth Court has issued an order to place a child into the care of the department, the **burden of proof is reversed**, and the parent must now provide evidence of a substantial change in circumstances that warrants reunification of their child to their care.

McLachlan (2023) proposes that, considering the severity of impact on a child of removing the child for a prolonged period from the care of its parent, there is a case for legislation governing the Youth Court to be adjusted to require the higher standard of proof of 'beyond reasonable doubt' rather than the current standards of 'on the balance of probabilities.'

f - Independence of assessors

One observation made by McLachlan (2023, page) is that professionals who submit assessments to the Youth Court are commonly employed by or funded by DCP (page). This raises questions of whether reports by assessors are independent, or whether there is a 'retainer bias' as the assessor wants to write a report that pleases the funder.

I note that Higgins (in press) points out that assessors on topics such as domestic violence provide reports to at least three court systems (Magistrate Courts, Family Courts, and Child Protection Courts), and he proposes that assessors be capable of providing reports to all three jurisdictions. Higgins recommends that assessors be employed independently of any party including a child protection department.

g - Trauma-informed service

This section addresses three topics that are relevant to a service being trauma-informed:

i. High rate of mental disorders in children in out-of-home care
ii. Externalising and internalising behaviours of children,
iii. Assessing parent-child attachment bonds.

i – High rate of mental disorders

A number of studies, including in South Australia, find that children who have been placed in foster care have high rates of mental disorder. Sawyer et al (2007) found that 61% of children placed in home-based foster care exhibited sufficient behavioural problems and are likely to likely meet criteria for having a mental disorder. Caregivers reported that 53% of children in their care required professional assistance, but only 27% of children had received professional assistance. Similar findings have been made in other studies, leading to a conclusion that simply placing a vulnerable child in a foster family is insufficient to ensure the child will enjoy good mental health (Reams, 1999; Millward et al, 2006; Minnis et al, 2006; Tarren-Sweeney, 2008; Pecora et al, 2009; Janssens & Deboutte, 2010).

ii – Externalising and internalising behaviours

Mental health professionals distinguish between two types of disturbed behaviour in children - internalizing behaviour and externalizing behaviour (Dagan et al, 2021). Externalizing

behaviours are visible acting-out behaviours that lead to diagnoses of conduct disorder and oppositional defiance disorder. Internalizing disorders are diagnosed when a child has internalised their distress, leading to diagnoses of anxiety and depression.

Many children display both externalizing behaviours and internalizing behaviours. There is a common view amongst mental health professionals that, when a child displays both externalising and internalising behaviours, their internal distress is likely to be driving their externalising behaviours. The conclusion is that a child who exhibits both types of disorder requires active therapy for their internalised condition from a skilled clinician, and not harsh discipline when they misbehave by acting out. This approach is called a 'trauma-informed approach.'

It is a concern if children placed in foster care do not receive adequate mental health care.

iii – Assessment of attachment bonds

The topic of attachment between a child and parent is important due to practices of DCP. If DCP considers that a mother remained for too long in a relationship that involved domestic violence, then DCP is likely to apply for a child to be removed from the care of the mother as the mother lacked protective capacity and prioritised her own needs over the needs of her child.

Removing a child from the care of its mother for a prolonged period while an investigation occurs is likely to produce harm for the child as the child's attachment bond is disrupted.

The concept of child-parent attachment was introduced by Dr John Bowlby in the 1950s, and there has been considerable discussion about how to assess attachment bonds. Literature about attachment can be divided into two segments; conclusions based on scientific studies; and other opinions. Appendix 7 cites reviews of scientific studies, and emphasises a review that was authored by 70 international researchers of attachment theory (Forslund et al, 2022).

Conclusions from reviews of research about parent-child attachment bonds that are relevant for legal purposes are summarised as:

a) Infants develop their first attachment bonds from the ages 6-24 months.
b) An infant who has learned to develop one attachment bond is better positioned to develop a further attachment with a secondary attachment figure, so children are able to form a limited number of bonds or multiple attachments, including with a foster carer and their parent.
c) Most children develop a primary bond and a few secondary bonds.
d) The quality of attachment bonds can be assessed to a level that is satisfactory for research and clinical purposes.
e) The science of attachment has not developed instruments to measure attachment that provide evidence that is suitable for legal purposes (van IJzendoorn et al).
f) A child's attachment bond is undermined by prolonged separation of the child from its primary attachment figure.
g) Undermining a child's attachment bonds is harmful for a child, and can produce lifelong negative consequences for a child.
h) When a child's attachment bond is undermined, the child passes through phases that are described as; protest at a separation; then despair at missing their parent and fear a reunification might not occur; then detachment and giving up all hope of reunification or being able to form another attachment (Robertson & Robertson, 1971).

i) The quality of attachments is usually described as secure or insecure. Studies find that only 55% of children develop secure attachments with a parent, and that many children have insecure attachments (van IJzendoorn, Schuengel & Balermans-Kranenburg, 1999).
j) Disruption of an insecure attachment bond has negative consequences for a child.
k) Finding that a child has an insecure attachment with a parent is not evidence that the child has been maltreated by the parent.
l) It is not necessary to reduce a child's contact with one parent to allow a child to build an attachment bond with a second adult.
m) Therapies have been developed to improve parenting when a child has an insecure attachment bond.
n) An attachment bond is revealed when a child is exposed to a mild challenge or hassle. Exposing a child to a challenge does not involve traumatisation of a child.
o) Children can form an attachment bond with a parent who mistreats them, including a parent who uses violence against a child.
p) An approach of 'therapeutic foster care' has been developed to provide a co-parenting approach for children who live in foster care and maintains their bond with their birth parent.
q) One role of an independent mental health expert who assesses a child is to inform a children's court about advances in research about parent-child bonds.

In a trauma-informed approach, the source of a child's distress is identified and treated. When a child has been removed from the care of a protective parent, the child is likely to be distressed due to the rupture of an attachment bond, even if the attachment bond was insecure.

There are two important implications for trauma-informed care:

i. It is very important to maintain a child's contact with their protective parent, so removal of the child's care from a protective parent who struggles should be an intervention of last resort rather than a first intervention while lengthy investigations occur, and
ii. Children who display distressed behaviour and who come to the notice of DCP require active therapy that is individualised to address the assessed needs of the child.

Q12 - Are elements in place in South Australia?

This submission proposes that most of the issues listed above are not adequately addressed under current arrangements in South Australia. The Government's emphasis on mandatory reporting of suspected maltreatment of children appears to have resulted in emergency health services prioritising mandatory notifications as being their sole responsibility, without any need to refer vulnerable families for early intervention therapy.

Under current arrangements, when a family's needs are assessed, the assessment is likely to be conducted by a worker funded by DCP who examines parenting capacity from a prosecution perspective rather than from a perspective of identifying any inadequate parenting practices that can be remedied using skilled and targeted interventions.

Summary

This section describes the following issues:

i. A number of evidence-based early intervention therapies that are trauma-informed have been developed and validated in international research for adult survivors of domestic violence, and for children who have been exposed to domestic violence.
ii. International research finds that children who have been removed from parental care and placed in standard foster care where they do not receive therapy experience high and ongoing rates of mental disorder.
iii. Prolonged removal of vulnerable children from the care of a protective parent introduces a significant risk that the child's attachment bond with their parent will be severed, increasing likelihood the child will develop a mental disorder.
iv. There are a number of barriers in South Australia for clinicians who aim to deliver early intervention therapy for vulnerable families.
v. Some of the barriers involve current legislation that provides limited protection for clinicians who provide reportable therapy for victims of domestic violence.
vi. Further barriers involve lack of reliable funding for clinicians who provide reportable therapy for families where domestic violence has occurred.
vii. Barriers also arise as, once a child is placed in DCP care, decisions about access to therapy are made by DCP case managers who prioritise topics apart from delivery of evidence-based therapies for vulnerable children.

Recommendations

I make the following recommendations:

i. That South Australia take a lead in legislating for and implementing best practice for children who have been exposed to trauma including trauma due to domestic violence.
ii. That the four categories of parenting identified in the 2009 National Framework for Protecting Australia's Children be endorsed in an amended CYPS Act to enhance delivery of trauma-informed therapy for vulnerable children.
iii. That the National Standards for out-of-home care be explicitly recognised in an amended CYPS Act.
iv. That the National Clinical Assessment Framework be recognised in an amended CYPS Act.
v. That an appropriate legal body clarify Rules of Evidence that apply to mental health professionals who provide therapy that is reported to a family-oriented court including FCFCoA and the Youth Court.
vi. That CYPS be amended to give the Youth Court greater authority to issue supervision orders even when a supervision order is not requested by DCP.
vii. That criteria associated with issuing of subpoenas be clarified in an amended CYPS Act, including clarifying information that will usually be sought when a subpoena is issued.
viii. That the question of reversing the burden of proof be reviewed in circumstances where DCP has reported there are risk factors for mistreatment of parents, but has not substantiated allegations about mistreatment of children to a legal standard of proof.

ix. For legislation to indicate that one role of an expert witness from social sciences and mental health is to inform courts about updated research findings that are relevant to issues being addressed by the court.
x. That an amended CYPS Act require courts give higher weight to evidence that is provided by assessors who are independent of DCP, and who strive to provide evidence that is objective as it is based on use of structured assessment instruments.
xi. That CYPS be amended to emphasise the need to use a trauma-focused approach with children who are assessed as displaying disturbed behaviours that appear to be trauma related.

D - RECOVERY AND HEALING

A recovery service is provided after a person has been injured. Recovery services are provided by rehabilitators.

Q13 - Universal needs

Similar mental health interventions are used for preventive interventions and for recovery. Further work will be required to distinguish between preventive interventions that might be provided to groups of individuals who are at risk but have not yet been injured, and rehabilitation interventions that are provided for people who have been injured or who are assessed as being at medium to high-risk of being injured.

Q14 - Support for victim recovering from trauma

There is considerable scientific literature about evidence-based interventions that are effective in helping people to recover from a traumatic experience including from trauma due to experiencing domestic violence. Relevant literature for treatment of trauma in adults is summarised in Appendix 2. Literature for treatment of trauma in children is summarised in Appendix 3.

Conclusions that can be drawn from the literature regarding adults are:

i. It is important to provide safety for adult victims of domestic violence by making referrals to police.
ii. Short-term cognitive behavioural therapy (CBT) interventions are available to help adults to recover from trauma, and these therapies have high efficacy.
iii. CBT therapy can be delivered as well as advocacy and practical supports by a clinical case manager. A clinician who uses a trans-diagnostic approach is able to address a range of relevant issues including: improve stress management skills, reduce anxiety, improve self-efficacy, improve safety skills, enhance social support, and improve associated depression.

Conclusions that can be drawn from the literature regarding children are:

i. Individualised therapies are available to help children to recover from trauma, including from trauma related to witnessing or being a victim of domestic violence,
ii. Effective therapies are based on principles of trauma-focused cognitive behavioural therapy (TF-CBT) and include an emphasis on: psychoeducation about trauma, emotion regulation strategies, cognitive processing, cognitive coping, imaginal exposure, enhancing safety, and problem solving.
iii. Effective therapies are provided by qualified therapists.
iv. Therapy is effective when children display both internalising symptoms and externalising symptoms, and when therapy is individualised to meet the needs of each child.
v. Including a protective parent in a child's therapy enhances efficacy, by providing joint parent-child therapy that focuses on a child's needs.
vi. It is easier to provide a coordinated therapy response when one skilled therapist who uses a trans-diagnostic approach delivers all components of therapy, rather than by referring a child to multiple therapists and requiring the child to repeat their story of trauma.

Trans-diagnostic therapy

The concept of trans-diagnostic therapy was discussed by Barlow et al (2017). A clinician who provides trans-diagnostic therapy is guided primarily by risk factors in a client, rather than by diagnoses of mental disorders such as provided by DSM-5.

Clinicians who practice in a trans-diagnostic way usually focus on interactions between family members or on family dynamics, as summarised by Wilson et al (2008), Garber (in press) and Tustin (c, in press).

A clinician who provides trans-diagnostic therapy is familiar with evidence-based interventions such as those described in the reviews of literature that are summarised in appendices.

Q15 - Are services in place in SA?

There are many clinical psychologists in South Australia who are trained in the trans-diagnostic approach and who are equipped to function as accredited clinicians for members of families who have been subjected to family violence.

While there are trained therapists, a high proportion of these therapists are reluctant or unwilling to provide therapy that is reportable to courts because of the numerous legal impediments that are discussed under Question 11.

In addition, trans-diagnostic therapy usually requires more than the 10 subsidised sessions that are funded per person under Medicare's Better Access scheme. It is possible to provide trans-diagnostic therapy to a parent-child combination if both family members are diagnosed by their GP as having a mental disorder, and if contact between the parent and child has not been restricted by DCP.

Summary

This section provides an overview of findings from research about trauma related therapies for adults and children.

Research has established strong evidence that certain therapies are effective in treating adults and children who have experienced domestic violence.

Therapies based on principles of cognitive behaviour principles have been shown to be effective in treating trauma, provided therapies are delivered by qualified providers. Components of effective therapies have been identified.

Before trauma related therapies are provided for children, an assessment is required of the balance between internalising and externalising symptoms displayed by each child, so individualised therapy is required.

Involving a protective parent in joint parent-child therapy has been shown to improve efficacy of interventions.

Effective therapy can be provided by clinicians who are trained to use trans-diagnostic therapies.

Many clinicians who are trained to provide trans-diagnostic therapies are not well trained in writing reports that meet legal standards for reportable treatments.

Research shows that the number of therapy sessions required to deliver effective trans-diagnostic therapies that are trauma-informed require more than the ten subsidised sessions that are currently provided by the Medicare Better Access scheme.

E - COORDINATION

Literature identifies at least seven models that are used to coordinate interventions for families who are involved in domestic violence. Models to coordinate interventions are described:

a. Inter-departmental collaboration
b. Administrative case management
c. Clinical case management / Trans-diagnostic therapy
d. Intensive wrap-around intervention
e. Court ordered case management
f. Therapeutic foster care
g. Shared care.

a – Inter-departmental collaboration

In an inter-department collaboration model, a family is referred to several departments of a state government, and the state government strives to provide a ‘whole of government response.’

The inter-departmental collaboration model appears relevant for families assessed as posing a severe level of risk.

b - Administrative case management

An administrative case manager controls a budget that is allocated for a client, but does not personally provide any specific service to a vulnerable family. An administrative case manager prepares a care plan, perhaps in consultation with family members who receive services.

The administrative case management model might be suitable for families where the level of risk is assessed as severe, and where many independent services need to be coordinated.

One issue that arises with the administrative case management systems involves the current lack of an assessment procedure that has been validated for the purpose of identifying the needs of various family members. This leaves an administrative case manager with considerable discretion to make decisions.

A second concern with the administrative case management model is that a case manager might presume that a protective parent lacks capacity to make decisions about delivery of services for the family, resulting in the case manager taking the decision-making role away from a protective parent.

A third concern with an administrative case management model is that an administrator might allocate tasks only to workers who belong to the same discipline as the case manager, or to close colleagues.

c - Clinical case management / Trans-diagnostic therapy

A clinical case manager is a clinician who provides services to address a major risk factor in a family, and who liaises with other service providers.

Traditionally a client's GP provides a clinical case management service for people with a diagnosed mental disorder as the GP prescribes medication.

A clinical case manager prepares a written care plan in negotiation with the family and other providers, and makes the plan available to all participants. A clinical case manager might advocate on behalf of a client to receive specific services.

A clinical case manager has skills to address the most important risk factors in a family, and operates using a trans-diagnostic therapy approach.

One version of clinical case management is described by Tustin (b, in press) who reports a clinician-led intervention that was conducted by the community mental health team at Adaire Clinic Noarlunga. The Adaire program combined clinical services delivered by a mental health clinician with in-home parenting coaching provided by a disability support worker who worked collaboratively with the clinician. Cases managed in the Adaire program included mothers who were diagnosed with mental health disorders of depression and anxiety following exposure to domestic violence, including where a child imitated some of the behaviours of an aggressive father or mother.

The clinical case management model appears relevant for families who are assessed as posing a medium level of risk, where there is more than one risk factor, and where individualised therapy is required.

d – Intensive Wrap-around Intervention

In an Intensive Wrap-around Intervention (IWI), a provider from an agency assesses a family's needs and provides services to meet all of a family's need from the agency. The purpose of Intensive Wrap-around Intervention is to enable a child or young person to remain living in their home. IWI services have been provided for families where young people display seriously disturbed behaviours.

In the IWI model, an administrative case manager might coordinate delivery of practical services, therapy services, and advocacy.

Different models of IWI are used in different jurisdictions and countries. One IWI model that provides an Intensive Family Preservation Service (IFPS) in USA is called the Homebuilders model (Forsythe, 1992). Characteristics of the Homebuilders model are: (a) agency refers families to services within 24 hours; (b) agency provides support to a family for 42-90 days; (c) agency works with families in their own home; (d) a caseworker is available 24 hours a day for 7 days a week; (e) a caseworker provides 12-15 hours of service per week for a family; (f) a caseworker has a small caseload of 2-3 families, or 5 families if para-professional assistance is provided; (g) the family unit is the focus of intervention; (h) the aim of strengthening capacity of parents is emphasised; (i) families are engaged in designing services they receive; and (j) families are linked to community services to provide outsourced therapy and other supports.

It is not clear that the model has been used in families where family violence has occurred.

Cox et al reviewed 30 intensive family support models for families with complex and multiple needs in Australia where children were at risk of maltreatment. They defined a model as providing intensive support if the family received a minimum of 4 hours support per week. Programs typically were intensive for 6 months, followed by less intensive input for a further 6 months. A critique by the reviewers found: components in programs lacked an evidence base; assessments did not match components to family needs; Aboriginal specific components were not routinely included; some families with multiple and complex needs received lower intensity interventions; the workforce was largely unqualified; and programs lacked a strong mdel of clinical governance.

Nelson et al (2009) reviewed research about IWI programs in USA that purported to use an Intensive Family Preservation (IFP) approach based on the Homebuilders model for families at high risk of having a child removed from parental care due to trauma. Nelson et al (2009) found that many programs lacked fidelity as they didn't follow procedures described in the original Homebuilders program. The authors noted a need to identify specific risk factors in each family and to provide specific interventions to target each identified risk factor in a family, rather than to provide a universal intervention to all at-risk families.

The criteria for efficacy of an IWI service used by Nelson et al were: d above 0.55 is a large effect, and d of 0.33-0.55 is a medium effect. They found only one study that reported a large effect size. Medium effect sizes were found in families where there were clear risk factors for children being removed from parental care.

A meta-analysis of IFP programs was provided by Bezecsky et al (2020) who reviewed 1948 studies. The review found reductions in risk of out-of-home placement in families who received IFP support with an effect size of d=0.57. In a related article, Bezecsky et al (2019) noted that

the aim of preventing all OOH child placements is not always appropriate, as there are circumstances where children are better off being removed from parental care. They noted that one aim of research should be to establish a threshold that distinguishes families where parents can and cannot be rehabilitated. Criteria to establish this threshold appear to have not yet been established.

e – Court ordered case management

Once a vulnerable family has been referred to an FCFCoA court, the judicial officer takes on the role of case manager. A judicial officer can issue orders for a certain family member to participate in forms of therapy or intervention that are designated by the court. The judicial officer might issue orders directing certain mental health clinicians to perform specific roles, perhaps without consultation with the clinician.

A judicial officer might identify criteria for therapy intervention to aim to achieve, such as abstinence from an illicit substance for a certain period of time. This role is useful as it provides a clear guideline for both a therapist and client.

f – Therapeutic foster care

A system of therapeutic foster care has been identified as a suitable approach for families with severe risk factors, where an assessment has been made that it is not safe for a child to continue living with either of their parents. One feature of therapeutic foster care is a clear arrangement for the child to maintain regular contact with their birth parent under specific conditions.

Foster carers who provide therapeutic foster care provide a higher level of service than traditional foster carers.

A meta-review of efficacy of **traditional foster care** was reported by Oosterman et al (2007). The review found that quality of caregiving by foster carers is one factor associated with breakdowns in placements. A meta-analysis by Goemans et al (2015) found that traditional foster care was not associated with either overall improvements or deteriorations in children's adaptive functioning or behaviour, indicating that simply placing a child in foster care without additional supports does not itself influence the trajectories of children.

A model of **therapeutic foster care** is described in a consultation report by the NSW Family and Community Services (2016), and by Frederico et al (2017), Harkness, (2019), and Mitchell et al (2020).

The NSW consultation paper identifies the following distinctive components of a model of therapeutic foster care (TFC):

a. A child is placed **singly** or in pairs with a foster carer who is carefully selected and matched to meet the child's needs.
b. An **individual treatment plan** is prepared that builds on the child's strengths.
c. The therapeutic **foster carer is empowered** to be the central agent and to make decisions to implement the child's treatment plan.
d. Implementation of the child's treatment plan is **oversighted.**

e. An **array of therapeutic interventions** is made available: to the child, to the child's birth family, and to the foster family.
f. Contact between the child and birth parents is **maintained** on an individually arranged basis to maintain the child-parent bond.
g. An option of a child **transitioning** to placement with their birth family while continuing to receive therapeutic supports is kept open.
h. Therapeutic foster carers receive **special training** on a range of topics that are relevant to children whose attachment bonds have been disrupted, and where children might have been traumatised.

Reddy and Pfeifer (1997) reviewed 40 studies of efficacy of Therapeutic Foster Care (TFC) and found that this model of care improved placement permanency, and improved children's behaviour problems, social skills and psychological adjustment.

McDonald and Turner (2007) conducted a meta-analysis of five studies that provided therapeutic foster care for 390 participants. Therapeutic / treatment foster care was defined as a foster-family based intervention that aimed to provide young people and their families with an individually tailored program that was designed to bring about positive changes in their lives. TFC was designed for children who were hard to place in foster care due to their difficulties and circumstances that introduced a risk of multiple placements and/or more restrictive placements such as hospital or secure residential or youth justice settings. The authors concluded that TFC is a promising intervention for children and young people with complex emotional, psychological and behavioural needs who are at risk of placement in out-of-home care. The study found clinically meaningful decreases in: children's antisocial behaviour; the number of days young people absconded from placements; the number of criminal referrals; and time spent in locked settings.

g – Shared care

Two pilot studies of shared-care / co-parenting between a foster carer and a birth parent have been reported. In a shared care model, a child spends regular time with their birth parent and a foster carer.

Landy and Munro (1998) reported a Shared Parenting program involving 13 families where the foster carer adopted a role of being a member of the extended family rather than a substitute family. The carer offered support and advice to improve parenting skills of birth parents, while providing secure accommodation for the children. The birth parent and foster carer worked as a team to meet the child's needs, with each having distinct roles that were resolved in each case. The level of contact between the child and the birth parent increased over time, with the child spending more time in the home of the birth family as the program progressed. Of the 13 families, 4 children were totally reunified with their parent, and 9 children remained in a shared care co-parenting arrangement.

Linares et al (2006) described a larger study in New York involving 128 children aged 3-10 years who had been in foster care for an average of 8.4 months. Children were assigned randomly either to a co-parenting group or to a control group. The co-parenting group participated both in a parenting course and in a joint course where carers and parents were helped to negotiate points of tension and conflict. The study found that intervention that combined co-parenting

skills and parenting skills produced significant gains for both biological parents and foster carers. Children's welfare was better in the co-parenting program.

Summary

This section has summarised information about models of care used to coordinate services for families who have been impacted by exposure to domestic violence.

The summary shows that many coordination models have been or can be used to ensure that care is provided in a collaborative manner.

This section proposes that it is viable to use five models to coordinate types of intervention as follows:

a. Delivery of **educational services** for families whose needs (risk level) are assessed as **nil** can be coordinated by **family members**.
b. Delivery of **preventive services** that can be provided in **group settings** can be coordinated by **family members**.
c. Delivery of **early intervention services** in families whose needs (risk level) are assessed as **medium**, where services are **targeted to address identified risk factors,** and where therapy is **individualised,** can be coordinated by a **clinician** who uses a trans-diagnostic approach. These families might have obtained their own intervention orders.
d. Coordination of **services** that require active involvement of many agencies or individuals, and where a family's needs are assessed as being very complex, and where a risk rating is **high**, can be achieved using a **Wrap-around model of care**.
e. Coordination of services where an assessment is made that risk is **unacceptable** can be provided by a **state agency**.

OVERALL SUMMARY

This submission proposes that it is important to divide interventions to minimise family violence into four categories such as prevention, early intervention, immediate response, and recovery. To achieve this categorisation, it is essential to introduce an evidence-based category system based on identification of risk factors for violence by individuals.

An overall framework is proposed to organise efforts to coordinate the four levels of intervention required to manage violence.

Define levels of intervention

The framework proposes the following definitions:

a. **Universal prevention** programs are available for families in the population where no risk factors have been identified.
b. **Psycho-education** programs are early intervention programs that are available for families where a low number of risk factors are identified, and where risk is assessed as low. Families are referred to voluntary programs that can be delivered in groups.
c. **Individualised rehabilitation therapy** programs are provided for families where a number of risk factors are identified or where risk factors are severe. Rehabilitation therapy is provided by skilled practitioners who might be asked to provide reportable

therapy. Access to family members might be dependent on compliance with participation in rehabilitation programs.

d. A **state-controlled intervention** is provided for families who are assessed as posing a **high risk** to family members, and where legal steps are taken to restrict access between family members, and to monitor compliance with orders.
e. Parents who are assessed as posing an **unacceptable level of risk** of harm to their children are subjected to ongoing restrictions to their access to their child.

Designate providers

It is recommended that the Government designate qualifications and terms for providers of each level of intervention, such as follows:

a. **Psycho-educators** provide early intervention programs
b. **Specialised clinicians** provide individualised rehabilitation therapy programs
c. **Judicial officers** authorise interventions that restrict access between family members.

This submission identifies a number of barriers that deter specialised clinicians from offering to work with children who are vulnerable due the family contact they live in. Each barrier is changeable with appropriate action by a State Government or a Commonwealth Government.

Scope of scheme

It is recommended that the proposed scheme apply to all courts that manage family-related disputes including Magistrate's courts, Family Law courts, and Child Protection courts.

Sincerely,

Dr Don Tustin

Clinical Psychologist

APPENDICES

Eight appendices are provided.

1. Universal parent education programs
2. Trauma therapy for adults
3. Therapies for traumatised children
4. Treatment of perpetrators
5. Therapies for parents with complex needs
6. Features of a subpoena
7. Scientific studies of parent-child attachment
8. References

Appendix 1. Universal parent education programs

There is an extensive scientific literature about parent education programs that have been shown to improve parenting skills, including when used with families where children are vulnerable to developing a mental disorder because of parental risk factors.

Two therapies are considered as preventive interventions:

i. Overview of parent education programs
ii. Triple P Positive Parenting Program.

i – Overview of parent education programs

Temcheff et al (2018) provided a review of 14 parent education programs that have been found to be effective with vulnerable families.

Temcheff et al identified components of effective programs as being:

a. have a clear objective of improving parenting skills, improving parent-child relationships, and reduce risk of maltreatment;
b. deliver psycho-education by a relevant accredited professional;
c. provide training for parents about methods of positive parenting including use of praise and reinforcement, positive communication, discipline, and regulate emotions;
d. provide joint parent-child sessions, and make flexible adjustments to meet a parents' needs;
e. use manualised interventions that document recommended procedures;
f. use a structured assessment instrument that documents family needs;
g. consider providing psycho-education for parents in a group context;
h. use educational methods that empower parents including modelling and video feedback of a parent's performance;
i. deliver some of the program in the home setting;
j. actively involve parents in the process of behaviour change by allocating responsibilities to the parent by using procedures such as homework assignments;
k. ensure that mechanisms are used to maintain the fidelity of interventions.

Temcheff et al reported that effective programs typically delivered sessions weekly for 1-2 hours. The duration of programs varied from 3-6 months, and were not prolonged.

Similar conclusions were reached in a review by Vlahovicova et al (2017).

A meta-analysis by Mingebach et al (2018) of 26 previous analyses of parent education interventions for children aged under 13 years who exhibited externalizing behaviours found an effect size of d=0.46 for child behaviour, d=0.51 for parent's reports about their child's behaviour, and d-0.62 for observations of children's behaviour. All effects remained stable after follow-up. Considerable heterogeneity within results was reported.

Triple P Positive Parenting Program

A parent education program called Triple P (Positive Parenting Program) has been developed by psychologists at the University of Queensland based initially on principles of learning. Use of the Triple P program has been supported by Commonwealth funding and has been used around the world.

The Triple P program is delivered in four levels according to assessed needs of a family. One level is a preventive program. Other levels are designed for families with specific needs.

A meta-analysis of efficacy of the Triple P Program was reported by de Graf et al (2008). They found that the Triple P Level 4 interventions reduced dysfunctional parenting styles in parents in families with special needs, improved parenting competency, and the effects were maintained over time.

A further meta-analysis of 101 studies involving 16,099 families who received PPP was reported by Sanders et al (2014). They found significant short-term effects for: children's social, emotional and behavioural outcomes (*d*=0.47); parenting practices (*d*=0.58); parenting satisfaction and efficacy (*d*=0.52); parental adjustment (*d*=0.34); parental relationship (*d*=0.22); child observation (*d*=0.50); and long-term parent observations (*d*=0.25). The reviewers reported that the positive results for each level of the multi-level Triple P system provide empirical support for a blending of universal and targeted parenting interventions to promote child, parent and family wellbeing.

Appendix 2. Trauma therapy for adults

A number of reviewers have addressed efficacy of therapy interventions for adults who are victims of domestic violence where interventions aim to reduce ongoing trauma following the exposure to domestic violence. This summary describes reviews in the sequence in which they were published.

Warshaw et al (2013) noted that many women remain under threat of stalking, and this complicates assessment of efficacy of therapy. It is important to provide suitable police protection as well as therapy.

Arroyo et al (2015) reviewed efficacy of short-term interventions to assist survivors of domestic violence. Their review of 21 studies found an effect size of d=1.02, and found that effects were

higher when Cognitive Behavioural Therapies interventions were tailored to the individual needs of survivors.

Johnson et al (2022) noted that interventions for women survivors of domestic violence often emphasise advocacy, case management, and provision of support groups. They argued there needs to be an emphasis on provision of therapy that aims to help survivors to manage their symptoms of PTSD and to empower the survivor.

Keynejad et al (2020) reviewed 15 studies for women who had a diagnosis of a common mental disorder and who had been exposed to domestic violence, where random controlled trials were used. They found that women diagnosed with anxiety showed greater response to therapy with an effect size of d=0.31, with lower efficacy for women who were diagnosed with depression.

Karakurt et al (2022) reviewed 25 studies involving randomized controls that provided therapy for female victims of domestic violence, involving 4683 participants. They found the following effect sizes: d=8.94 in improving stress management skills; d=7.15 in improving anxiety; d=1.33 in improving self-esteem; d=0.92 in improving measures to prevent violence; d=0.43 in improving safety; d=0.40 in improving social support; and d=0.26 in improving depression. The review found that untreated exposure had long-lasting, and effective treatments were individualised and targeted co-morbid issues including improving a victim's safety and their mental health issues.

Appendix 3: Therapies for traumatised children

A number of therapies have been developed to assist children who have experienced trauma and who display disturbed behaviours.

Three approaches to provide therapy for children who have been exposed to domestic violence are described:

a. Trauma-informed therapy for children
b. Joint parent-child therapy
c. Therapy for a parent to reduce inappropriate parenting practices.

a – Trauma-informed therapy for children

Gillies et al (2016) reviewed efficacy of psychological therapies for children who were exposed to various forms of trauma reported in 51 studies including exposure to domestic violence. Most trials used a cognitive-behavioural therapy (CBT) approach. The review found that therapies reduced symptoms of PTSD in children, with an immediate effect size of d=0.42.

Dorsey et al (2017) reviewed 21 studies and found interventions that were effective in reducing children's trauma involved CBT that combined six elements: (a) psychoeducation about trauma prevalence, impact and the intervention; (b) training in emotional regulation strategies of relaxation, labelling emotions, and cognitive coping; (c) imaginal exposure; (d) in vivo exposure; (e) cognitive processing; and (e) problem solving. The Dorsey review included studies that

included involvement of protective parents. The reviewers concluded that involvement of protective parents is beneficial for children if: a child is aged 3-6 years; a child displays behavioural problems; and the parent involved in therapy has a mental health condition such as anxiety.

Bartlett et al (2018) reported a study where one of three therapies was administered to a total of 839 children in care who had a mean age of 9.4 years and who had experienced complex trauma. They reported that therapies could be delivered to children in care using the following numbers of sessions: 21 sessions for TF-CBT, 16 sessions for Child-Parent Psychotherapy, and 21 sessions for an Attachment, self-regulation and competency program. The authors reported reductions in parent/caregiver and youth reported symptoms of PTSD, improvements in parent/caregiver reported child behaviour problems, and improvements in strengths and needs of children/youth.

A meta-analysis and review of 56 randomised controlled trials involving 5327 patients that compared efficacy of 14 different types of psychotherapy for trauma in children was provided by Xiang et al (2021). They found that cognitive processing therapy, behavioural therapy, and individual trauma-focused cognitive-behavioural therapy were most effective for treating trauma in young people. Each therapy was provided by qualified therapists.

Romano et al (2021) reviewed 21 studies to evaluate interventions that included children and found an effect size of d=0.49. Improvements were maintained when children had internalizing disorders. When children had externalizing disorders, the effect size was lower at d=0.36. They noted that interventions are improved when they are more tailored to meet the specific needs of individual children.

Thielmann et al (2022) reviewed efficacy of trauma-focused cognitive behaviour therapy (TF-CBT) that was reported in 28 random controlled trials involving 4523 participants. They found an effect size of d=1.14, with a reduction in symptoms of stress symptoms d=0.52. Children displayed symptoms of posttraumatic stress, anxiety, depression and grief. TF-CBT was defined to include components of: (a) psycho-education about prevalence of trauma and symptoms of stress to normalise the child’s and parent’s experience; (b) teaching children coping strategies; (c) educate child to turn to parent for help when stressed; (d) emphasise joint parent-child enjoyable activities; (e) emphasise maintenance of usual basic routines; (f) encourage approaching challenges and supervised exposure , avoid over-protection; (g) promote relaxation and self-regulation of negative emotions; (h) identify children’s and parent’s unhelpful thoughts and replace with realistic helpful thoughts; (i) distinguish between a child’s thoughts, feelings and actions, and explain links between these; (j) encourage child to describe the traumatic incident calmly and sequentially – if the child is not to be a witness in court; (k) help the child to identify reminders of traumatic incidents, and develop non-avoidant safety plans to manage future encounters; (l) parent to model good calm coping skills; (m) ensure child and parent are confident they have a realistic safety plan for the future; and (n) encourage parent and child to look towards the future rather than to the past.

Szota et al (2023) reported a meta-analysis of 33 studies where parents had been involved in therapy interventions for children and young people who experienced symptoms of a mental disorder due to a trauma. They found an effect size of d=0.34 for improvements reported by children, and an effect size of d=0.41 for improvements reported by parents. The authors concluded that interventions involving parents produced greater reductions in symptoms.

Ko et al (2008) identified the difficulty of coordinating therapy responses across government departments, and proposed that independent therapists be used to deliver trauma-informed therapy services to children in welfare services.

It is concluded that therapies to assist children who have experienced trauma due to exposure to traumatic events are well established.

b – Joint parent-child therapy

Therapies have been developed that provide joint parent-child sessions and include teaching parents skills to manage distressed behaviours of children who have been traumatised. Joint therapies focus on interactions between a parent and child, and not only on the behaviour of one participant. Reviews find that joint parent-child therapies are effective for vulnerable families, with Hackett et al (2015) finding from a review of 17 studies involving joint therapy for children and their non-offending parent that this approach had a large effect size of d=0.81.

Six joint parent-child therapies are discussed. The therapies differ in the theories used to derive the therapies. The therapies are:

i. Parent-child interaction therapy
ii. Child-Parent psychotherapy
iii. Functional therapy in child welfare
iv. Attachment focused therapies
v. AF-CBT
vi. Therapies to reduce maladaptive parenting.

i - Parent-child Interaction Therapy

A Parent-child Interaction Therapy (PCIT) program was described by Bodiford-McNeil and Hembree-Kigin (2010). The PCIT program was designed to assist parents whose children display conduct problems.

PCIT uses a distinctive approach as a parent wears a device that allows a coach behind a one-way mirror to give instructions while the parent interacts with their child, using 12-18 sessions.

A meta-analysis of 23 studies using PCIT by Thomas et al (2017) found PCIT to be effective in reducing children's externalizing behaviours. The analysis considered whether programs required parents to demonstrate mastery of skills taught in the program and found that parents who were required to demonstrate mastery achieved significantly greater reductions in their children's externalizing behaviour than parents who were not required to demonstrate mastery. PCIT was found to significantly reduce parent-related stress, and to increase children's compliance with parental requests.

A meta-analysis by Kennedy et al (2016) found that parental participation in PCIT was associated with significantly fewer recurrences of physical abuse.

A meta-analysis of 12 studies of PCIT that included use of control groups and where children were aged 2-5 years was reported by Ward and Theule (2016). They found that PCIT had a large

effect of d=1.65 on improving externalizing behaviour problems in children with disruptive behaviour disorder.

A study by Bjørseth and Wichstrøm (2016) found that children who received PCIT during regular clinical practice exhibited a greater reduction in behaviour problems compared with children who received usual treatment (d=0.64), and the parenting skills of these parents improved to a greater degree compared with those who received usual treatment.

ii - Parent-child psychotherapy

Chamberlain (2014) reported use of a Child-Parent Psychotherapy (CPP) approach for non-offending parents and children who had been exposed to domestic violence, using 12-40 sessions. Children who participated in CPP showed fewer symptoms of trauma and fewer behaviour problems, and their mothers displayed less severe symptoms of mental disorder.

ii - Functional Family Therapy for Child Welfare (FFT-CW)

A program called Functional Family Therapy for Child Welfare (FFT-CW) was described by Alexander et al. (2011, 2013). FFT-CW is based on principles for family systems and uses cognitive-behavioural interventions to address issues of abuse, neglect, and associated issues. Interventions can be delivered at two levels; where one level is delivered by case managers, and a second level is delivered by therapists. FFT-CW interventions are delivered in five phases: engagement; motivation; relational assessment; behaviour change; and generalization. Manualised training is available (Alexander et al, 2013). Intervention is delivered weekly, and commonly takes 5-7 months to deliver.

A report about efficacy of the FFT-CW program in NSW Australia was provided by Economidis (2021). One aim of the program was to reduce need for out-of-home placements for children at risk of harm. The study found that children or young people whose family didn't complete the FFT-CW program had up to 14.3 times the odds of entering OOHC within 12 months of their notification compared to children or young people whose family did complete the high track version of FFT-CW.

A meta-analysis of 14 studies using FFT-CW by Hartnett et al (2017) found that results provided support for the effectiveness of FFT compared with untreated controls for adolescents.

iii – Attachment focused therapy

In a textbook for clinical psychologists, Carr (2006, 2018) discussed assessment and attachment focused interventions for vulnerable families where a child is being considered for foster care. Carr noted that children aged 6-48 months are especially sensitive to separations from their attachment figure, and that children who have formed insecure attachments with their parent are especially sensitive to separations. Carr emphasised that interventions need to include careful consideration of a child maintaining their attachment bonds.

Carr commenced by noting that children go through three distinct phases when they are separated from an attachment figure, involving protest, despair, and then detachment. A child in the despair phase is giving up hope of being reunified with their parent and becomes

unmotivated and listless. A child in the despair phase is not ready to form a new attachment bond, as the child fears the pain of further abandonment. A despairing child is likely to resist efforts by a foster carer to form a bond. A despairing child might test the carer by acting out aggressively in an unconscious attempt to see whether the carer will also reject them. If a child enters the detachment phase, they are at increased risk of developing a long-term mental disorder.

Carr noted that some welfare workers adopt simplified binary thinking and consider only two of the four available solutions. Carr proposed that moving to a multi-disciplinary approach by seeking an assessment from a specialised psychologist helps to reduce restricted binary thinking. Carr provides frameworks to use when assessing cases of neglect and abuse.

Carr noted that a child who is moved and provided with multiple placements might learn to avoid hurt that is associated with the disappointment of forming close emotional relationships that are then severed. The child might learn instead to form shallow relationship with several people, called an approach of indiscriminate attachments.

iv – AF-CBT

Kolko et al (2011) described an intervention called 'Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT)' that was delivered by clinicians on different sites to 52 families where a child aged 3-17 years had been sexually abused, or physically abused, or subject to severe or frequent physical punishment, or had been exposed to family violence. Therapy was individualised and provided an average of 26 sessions, with a mean of 21 sessions devoted to face-to-face visits with the child, 10 sessions of parent-child therapy, and 4 sessions of parent/caregiver-only therapy. Both therapists and parents rated children's progress using several measures. Improvements were found on aggregate ratings indicating that children were less scared/sad and were happier, felt safer from harm, were better able to not harm friends, and were less likely to intrude on the privacy of others. Therapists reported that they taught parents specific skills to manage a child's behaviour and to regulate children's emotions.

v – Common principles in joint parent-child therapies

Broad principles that are shared in joint parent-child therapies were summarised by Greenberg et al (2012), who introduced an integrated model of therapy called Child-entered Conjoint therapy (CCCT). Components to include in a CCCT approach are: (a) focus on parenting practices; (b) identify situations that are challenging for a child and assist the child to find prosocial ways to manage the challenges, rather than focus on a child's behavioural difficulties; (c) protect a child from unreasonable hazards; (d) clarify how each family member perceives challenges; (e) clarify rules the family will accept and establish boundaries that will be respected by the family; (f) state boundaries in terms of specific behaviours rather than character qualities; (g) allow a distressed child to express their feelings using words that are acceptable in the family and in society; (h) encourage a child to own their feelings even when their feelings are set off by an external trigger by saying 'I feel x when y happens;' (i) clarify routines that promote acceptable behaviours; (j) encourage all family members to not behave in ways that distress other members; (k) distinguish between goals/values and behaviours, and focus on behaviours that achieve goals; (l) identify discrete situations that are associated with

tensions, and clarify appropriate behaviour to manage these challenging situations; (m) use methods of positive discipline that minimises use of punishment for a child who is distressed; (n) avoid making arbitrary restrictions to a child's access to pleasurable activities that are unrelated to the child's behaviour , and use safe natural consequences; (o) encourage parents to apologise to their child when they make a mistake; (p) encourage parents to be a good role model for their child; (q) avoid blaming the other parent for causing children's behaviour problems; (r) encourage the child to follow normal routines and rules and don't make excuses for misbehaviour; and (s) don't allow the child to see the parent preoccupied by adult problems.

Shafi et al (2019) reviewed efficacy of four joint parent-child therapies for children aged up to 5 years who experience emotional and behavioural difficulties. They recommended that early intervention therapies be offered while children are pre-schoolers. Their review identified dyadic therapies that improve the parent-child relationship as being most effective than providing therapy only for a child. They comment that therapists who are familiar with both child- and adult-oriented therapies to manage dynamics in vulnerable families provide therapy that is most effective. They reviewed four evidence-based therapies: **Child-parent psychotherapy** (CPP), **Trauma-focused cognitive behavioural therapy** (TF-CBT), **Parent-child interaction therapy** (PCIT), and **Child parent relationship therapy** (CPRT).

CPP used a play approach to encourage parents to recall their own childhood experiences, and to avoid repeating use of inadequate parenting practices with their own child. CPP required about 100 sessions. The effect size for CPP was reported by the developers as d=0.40.

c – Therapy for a parent to reduce inappropriate parenting practices

Some therapies focus on improving inadequate parenting practices used by parents who have been diagnosed as having a mental disorder. Tustin (a, in press) summarises specific parenting practices that are inadequate in meeting a child's needs and that are associated with parental mental health conditions of depression, anxiety and mood disorder.

LeBuffe and Shapiro (2008) noted that parents with a mental illness are often apprehensive about consulting professionals as they expect to be confronted with an idea that their child's misbehaviour shows they are an inadequate parent, so many parents react defensively and avoid seeking help. LeBuffe and Shapiro emphasised the importance of using assessment tools that highlight a child's and parent's strengths on topics such as attachment, initiative and self-control, as well as noting shortcomings. The authors recommend that information be obtained from both a parent and teacher, and that information be presented by displaying profiles obtained from both sources. The authors opine that an approach of sharing positive information as well as information about shortcomings builds healthy parent-professional partnerships.

A review by Mikton and Butchart (2009) examined types of intervention that are effective in reducing maltreatment of children when a parent has a mental illness. They identified three promising types of intervention: parent education, home-visiting and in-home parent coaching, and interventions that offer individualised components to address specific risk issues.

Euser et al (2015) synthesized findings from 27 independent randomized controlled trials to assess the efficacy of 20 different intervention programs that aimed to: (a) prevent the occurrence of child maltreatment in the general population and with at-risk but non-maltreating

families; and (b) reduce the incidence of child maltreatment in maltreating families. The combined effect size was d=0.13. A larger effect size of d=0.35 was obtained from programs that provided parent training instead of only support, from programs that targeted specific maltreating behaviours, and when programs had a duration of 6–12 months and provided 16-30 sessions.

Chen and Chan (2016) analysed 37 studies about the efficacy of parenting interventions to prevent child maltreatment. They found that parenting programs that aimed to reduce risk factors and enhance protective factors associated with child maltreatment reduced substantiated and self-reported child maltreatment reports, with an effect size of d=0.296.

Vlahovicova et al (2017) reviewed 14 studies about interventions to prevent recurrence of child abuse and reported that interventions based on social learning theory reduced hard markers for recidivism of child physical abuse.

Van der Put et al (2018) reviewed 121 studies involving 39,044 participants that aimed to reduce maladaptive parenting practices. They found that effective programs provided cognitive behaviour therapy, home visits, training in parenting skills, were family-oriented, and included a focus about impacts of substance misuse on children. Effect size for curative interventions was d=0.36, and for preventive interventions was d=0.26. Preventive interventions were more effective when they aimed to improve parenting confidence and were delivered by independent professionals. The efficacy of good preventive programs increased with passing time. Curative programs were improved if social and emotional support was added.

Penner-Goeke et al (2023) reported an intervention program called BRIDGE that treats mothers of children aged 3-5 years who display depressive symptoms to prevent the inter-generation transmission of depression.

Appendix 4. Treatment of perpetrators

Several writers have reviewed efficacy of treatments for perpetrators of domestic violence. Reviews are addressed in their order of publication.

A review by Babcock et al (2004) found that therapies had **minimal impact** on reducing recidivism for perpetrators of domestic violence.

Echardt et al (2013) reviewed a number of studies that delivered ‘traditional forms of intervention’ for perpetrators and found equivocal results.

Cheng et al (2019) reviewed efficacy on recidivism in perpetrators that were reported in 14 studies that met high scientific standards by using a control group. They found that interventions reduced recidivism as assessed by data from the criminal justice system, but not as assessed by self-reports of survivors of violence.

A review by Karakurt et al (2019) found three controlled studies that involved 223 perpetrators of domestic violence. They reported an effect size of d=0.85 from pre-test to post-test scores. Higher efficacy was achieved when interventions also addressed associated substance misuse and trauma.

In contrast, a review by Bell and Coates (2022) concluded that only one of 29 reviews found that unspecified behaviour change interventions for perpetrators had worked. They concluded that intervention orders reduced the severity of violence, but not the prevalence of violence. They found that reporting incidents to police reduced re-offending.

Appendix 5: Therapies for Parents with complex needs

a - Couple therapy

Stith, Rosen and McCollum (2007) discussed use of couple therapy when couples have engaged in domestic violence. They found six relevant studies, where studies used differing eligibility criteria, treatments, and outcome measures.

Karakurt et al (2016) identified six informative studies and concluded that couple therapy may be more effective with couples who engage in situational domestic violence.

Snyder and Halford (2012) reported that several models of couple therapy reduce couple distress for many couples, but that 25-30% of couples show no benefit.

Spengler, Lee, Wiebe and Wittenborn (2024) conducted a meta-analysis of use of Emotionally Focused Couple therapy across 20 studies involving 332 couples with issues regarding depression, PTSD, and sexual dissatisfaction. They found medium to large effect sizes with d=0.93 when EFT was used, compared to d=0.44 when other treatment modalities were used.

LeBow (2014) reports that, while a wide range of interventions are used in couple therapy, there are common elements in effective therapies. Common elements in models of couple therapy include: promote mutual empathy and understanding; encourage negotiation between partners; focus on strengths in the relationship and each other's strengths; emotional re-engagement and positive connections; understanding of individual contributions to issues; and emotional regulation to allow discussions to occur in a debating style.

b - Parental mental illness

Bee et al (2014) reviewed 26 trials where mothers of infants with severe depression were provided with psychological interventions. The review found medium-large effects of depressive symptoms on parenting behaviours (d=0.67).

Siegenthaler et al (2012) reviewed 13 random control trials that provided interventions that aimed to prevent transmission of mental illnesses from parents with a mental illness to their offspring. The review included 1081 parents and 1490 children. The review found that interventions that treated parental mental illness significantly decreased the risk of children developing the same mental illness that their parent was diagnosed with. Interventions significantly reduced risk of children developing internalizing disorders (d=0.22), but only treating a parental mental illness did not significantly reduce risk of children developing externalizing disorders.

Stewart-Brown and Schrader-McMillan (2011) reviewed research about interventions for parents with a mental illness. They identified maternal depression as a condition that needs to be monitored and treated. They identified child-parent attachment as a risk factor to address, and identified effective therapies for this issue. Effective therapies provide home visits, video feedback of interactions, and focus on parenting behaviours that promote attachment. Programs to improve parenting skills have been found beneficial for parents with mental health difficulties. Programs that aim to enhance a parent's skills and confidence need to focus on parenting strengths and to be viewed by parents as being non-judgmental.

No research was identified by Stewart-Brown and Schrader-McMillan (2011) that identified a threshold of severity of parental mental illness that rendered a parent incapable of providing adequate parenting.

c - Parental substance misuse

If a parent is diagnosed with a mental health disorder, then the aim is for the parent to use prescribed medications and to be abstinent from illicit substances for at least one year.

An early review of studies by Stanton et al (1997) found that couple or family therapy was more effective than individual therapy in reducing substance misuse in parents.

A meta-analysis by Prendergast et al (2002) found that drug abuse treatment achieved a clinically meaningful reduction in substance use. Burke et al (2003) identified the intervention of motivational interviewing as producing moderate effect sizes of d=0.25 to d=0.57. Lundahl et al (2010) reported a review of 119 studies that used motivational interviewing to reduce use of various substances, and found an average effect size of d=0.28, showing that motivational interviewing was as effective as other interventions. Jensen et al's (2011) review of 21 studies found an effect size of d=0.14 on alcohol and drug use due to motivational interviewing, with efficacy continuing for 6 months. Smedslund et al (2011) reviewed 59 studies and found that the effect size achieved by motivational interviewing reduced over time, being d=0.79 post-intervention, and reducing to d=0.17 at short-term follow-up, and to d=0.15 at medium term follow-up, but follow-up periods were not published. However, an analysis by Li et al (2015) found an effect size of motivational interviewing on drug use was only d=0.05.

Magill et al (2009) reported a meta-analysis of 30 controlled trials that used cognitive-behavioural therapy (CBT) for substance use disorders, and reported moderate to significant effect sizes. CBT therapies were defined as multi-session interventions that target cognitive, affective and environmental risks for using substances, together with teaching coping skills to manage risk factors and to maintain abstinence or harm reduction, with an emphasis on relapse prevention.

Li et al (2017) reported a review of 42 studies into efficacy of mindfulness treatment on substance misuse, and reported a range of effect sizes from small to large.

Beaulieu et al (2021) acknowledged that substance use disorder is a chronic condition as relapses can occur. They reported a high rate of relapse into substance misuse following therapy. They measured efficacy of interventions that provided support for a period of 18 months, and found that people supported by a longer-term intervention had a 24% higher chance of remaining abstinent.

In summary, reviews of efficacy of therapies designed to reduce substance misuse report variable results, indicating that individual assessments need to be made in each case.

Appendix 6: Features of a subpoena

A Court can issue a subpoena that compels a mental health clinician to provide to a court confidential clinical information collected by a therapist. A subpoena overrides any confidentiality arrangement a therapist / clinician has made with their client, as therapists have no legal privileges.

Before a court issues a subpoena, the applicant must provide information that the requested information is relevant to the primary issue in a case, and explain how the requested information will materially assist the court to resolve the case.

A subpoena might be issued on the grounds that a therapist is suspected of acting in a way that is illegal or that contradicts an established code of practice, so information sought in a subpoena is potentially incriminating for a clinician. This is of concern as here is no written Code of Practice for mental health clinicians who provide therapy for members of vulnerable families.

The usual features when a court issues a subpoena for the file of a mental health therapist appears to be as follows:

a. A **written** subpoena is issued
b. The subpoena states the **precise information** that is to be provided to a court.
c. A subpoena might indicate the **reason** the required information is relevant to the case in court.
d. The subpoena states a **time period** for the clinician to comply with the order, commonly about 21 working days.
e. A respondent is given an opportunity to **object** to a subpoena.
f. If a subpoena is provided, then the **consent of the client** involved is not required before information is transferred.
g. The subpoena states who requested documents must be provided to, and this is commonly the judicial officer who presides over the court, not to one party.

Grounds for objecting to a subpoena

As a subpoena represents a significant breach of a person's privacy, a respondent to a subpoena may appeal against a subpoena.

The following grounds might be cited as grounds of appeal.

Not authorised to disclose

A client might have passed to their therapist documentation that originates from a third party who has not given permission for the document to be passed on. In this case, a therapist who makes an unauthorised disclosure is at risk of legal action for breaching the confidentiality of the third party, if the document is passed to participants in dispute before a court.

Appendix 7 – Studies of parent-child attachment for legal purposes

A number of reviews of literature have been conducted about use of the concept of parent-child attachment in child protection cases including by Granqvist et al (2017), van Ijzendoorn et al (2018), van IJzendoorn, Steele and Granqvist (XX), van IJzendoorn et al (1995, 1999, 2018, 2019, 2020), Forslund et al (2022), Hammarlund et al (2022), Arrendondo and Edwards (2000), Fearon et al (2010), Cyr et al (2010, 2020), Lee, Borelli and West (2011), Zilberstein (2014), Verhage et al (2016), Khoury et al (2020), and Zajac et al (2020).

Granqvist et al (2017) discussed the increased use of concepts from attachment theory in child protection courts and noted that false assumptions and misconceptions have emerged. One misconception is that certain types of attachment are reliable indicators that a child has been maltreated and is a strong predictor of pathology for individual children. Granqvist noted that some misconceptions arise as commentators interpret results applying from correlations found in studies of group of people to be applicable to all individuals in the group.

Van IJzendoorn et al (2018) wrote to express their high concern that concepts from attachment theory were used in child protection courts to promote removal of children from the care of their parents. Van IJzendoorn and colleagues pointed out that instruments used to assess parent-child attachment lack reliability, and that no assessment instrument has not been shown to be valid when used to make predictions about future outcomes for individual children. Van IJzendoorn et al argue that existing instruments to measure attachment concepts assist researchers and clinicians, but instruments do not provide the level of certainty that is required to meet standards of evidence required by courts.

Hammarlund and colleagues studied practices of child protection workers in Sweden and found that the vast majority of workers formed opinions about a child's attachment quality without using any assessment instrument, and they were over-confident in their subjective assessments about attachment relationships. One false belief held by workers was that an insecure attachment bond indicated that insufficient care had been provided by their parent, and this warranted removal of a child from parental care.

Forslund et al

A review paper by Forslund et al (2022) is co-authored by 70 researchers of attachment theory. The authors write that attachment theory has been developed over decades to assist researchers and clinicians to understand processes by which children become attached to their carers.

Key points from the Forslund review that are relevant for courts are:

- **Attachment** refers to an emotional / affectional bond where an individual is motivated to seek and maintain proximity to, and comfort from, particular familiar persons (page 7).

- **Secure attachment** relationships are indicated by children's behaviour that suggests a child expects the attachment figure to be available in times of need, and **insecure attachment** behaviour suggests the child does not expect unavailability (page 8).
- The quality of attachment in an infant is reflected by an infant's proximity to an adult. A child's motivation to increase their proximity to an adult is **activated** when the child is mildly alarmed or challenged (page 7).

- The quality of attachment cannot be determined from **isolated behaviours** such as crying (page 9).

- 'There are widespread **misunderstandings** regarding the nature of attachment, including assumptions that children are born attached; that attachment equals attachment quality; that isolated behaviours reveal attachment quality; and that attachment quality equals relationship quality, caregiver sensitivity, or "strength" of attachment.' (page 7).
- Although some types of attachment relationships are termed "insecure", they are nonetheless regarded as adaptive strategies for children who may maximise the potential availability of a caregiver (page 10).
- 'In fact, children develop attachment relationships even if their caregivers are **rejecting**, inconsistently sensitive, or abusive.' (page 10).
- Most children form **multiple attachment relationships** (page 8).
- 'It is often assumed that an attachment relationship with one person is **at the expense** of other attachment relationships, and that best-interest decisions should maximise the likelihood of secure attachment with one "primary caregiver".' (page 11).
- 'children can develop and maintain secure attachment relationships to **multiple caregivers simultaneously**' (page 11).
- 'This **multiple caregiver phenomenon** is indeed the norm in many **cultural settings** (Hrdy, 2011). Multiple caregivers and a network of attachment relationships have also been found to constitute a **protective factor** in child development, with secure attachment to one person buffering the implications of insecurity in other relationships.' (page 11).

- 'We are in **full consensus** that the ultimate establishment of a **network** of attachment relationships is generally a **protective factor** in the long term and thus a desirable outcome in child development.' (page 13).

- 'We are also in full agreement that **losses of and permanent separations from attachment figures are in themselves risk factors** that should be prevented wherever possible in child development.' (page 13).

- Judging from their sequelae, the former (e.g. child removal) is generally a much more **profound risk factor** in child development than the latter.' (page 24).

- '**considerably depriving** a child of time with a parent is itself a **risk factor** for insecurity and disorganisation in that relationship. Returning to the distinction between attachment quality and overall relationship quality, insecurity does not mean that a child does not benefit from the relationship with a parent.'

- ‘***Extreme caution*** *should therefore be exercised in disrupting children’s attachment relationships*.’ (page 25).
- ‘Ultimately, attachment theory and research stress the importance of sufficiently **continuous availability** of familiar non-abusive, non-neglecting caregivers as a general principle (Bowlby, 1958).’ (page 25).
- ‘Maintaining attachment relationships with **both foster and biological parents** often constitutes one of the main objectives of foster care, and research has suggested that foster children can be supported to develop and maintain attachment relationships with both their biological parents and their foster parents without conflicting loyalties.’ (page 29).

Appendix 8: References

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