



Families with multiple and complex needs

Best interests case practice model
Specialist practice resource

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2012

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About specialist practice resources

The Best interests case practice model provides you with a foundation for working with children and their families. *Specialist practice resources* have been developed to provide additional guidance on information gathering, analysis and planning, action, and reviewing outcomes in cases where specific problems or complex issues exist, or which involve particular developmental stages in children.

Specialist practice resources are a valuable tool for practitioners, but do not replace the online Child Protection Practice Manual, which contains information about procedural requirements, practice standards and advice. The *Families with multiple and complex needs* specialist practice resource is designed to complement and enhance your practice with families as you fulfil your statutory role.

This resource consists of two parts: Part One is an overview of issues and considerations relevant to families with multiple and complex needs, and Part Two contains practice tools to guide you when working with these families.

Overview

What are multiple and complex needs?

Terms linked to the concepts of multiple and complex needs and used by various disciplines include (Children's Development Workforce Council 2011):

- multiple disadvantage
- multiple adversities
- multiple disabilities
- multiple impairments
- dual diagnosis (that is, someone diagnosed as having more than one condition)
- high support needs
- complex health needs.

A definition of multiple and complex needs implies both:

- breadth of need – multiple needs that are interrelated or interconnected.
- depth of need – profound, severe, serious or intense needs (Rankin and Regan 2004).

Rather than use the term multiple and complex needs to describe a person's characteristics, it is more helpful to use it to describe the array of problems confronting a person that frequently span social, economic and health issues, and as a framework for understanding and response.

People with complex needs may have to negotiate several issues in their life, such as physical or mental illness, substance abuse and disability. They may be living in deprived circumstances and lack access to suitable housing, employment or meaningful daily activities.

Each individual with multiple and complex needs has unique concerns tied closely to the interaction between his/her social, economic and health care needs, and so requires an individualised response.

Within child protection and family intervention work, the phrase 'multiple and complex needs' can be used to refer to families presenting with circumstances and behaviours that are having negative consequences for family members, particularly children.

Who are families with multiple and complex needs?

Families with multiple and complex needs may be experiencing numerous, chronic and inter-related problems. These families do not constitute a homogenous group and should not be labelled or assumed to be 'forever' in this state. There is significant diversity among these families, which indicates the complexity and multi-dimensional nature of the problems they experience and the need for individualised, tailored and flexible approaches to assist them.

Increasingly, families with multiple and complex needs have become the primary client group of modern child protection services. Recent research has shown that they typically have five or more disadvantages including living with poverty, unemployment, poor quality housing and disabilities (Social Exclusion Taskforce, UK 2007).

Victorian data shows family violence, substance abuse and mental illness as commonly co-occurring difficulties for families involved with child protection (Allen Consulting 2002), a pattern also reflected in the analysis of child death reviews (Victorian Child Death Review Committee 2009). It is also common to find parents with disabilities including learning disabilities, intellectual disability or acquired brain injury among those families experiencing multiple and complex needs.

Recent Victorian data confirms the co-existence of many family background factors for children entering out-of-home care for the first time. Of 332 children entering out-of-home care in 2006–07 (Delfabbro, Kettler & Fernandez 2012):

- 0.3 per cent had 1–3 background factors
- 13 per cent had 4–6
- 49 per cent had 7–10 and
- 39 per cent had 11 or more family factors that contributed to their placement.

The most commonly identified family background issues included:

- a parent unwilling or unable to care for the child (91 per cent)
- emotional abuse (83 per cent)
- family violence (83 per cent)
- substance abuse (80 per cent)
- physical abuse (77 per cent) and
- neglect (75 per cent).

Most families were also affected by financial and housing problems (Delfabbro, Kettler & Fernandez 2012).

Experiencing serious, multiple disadvantage cuts across many domains of family life. Families with multiple and complex needs are likely to have difficulties meeting the needs of their children and parenting effectively. Children can be at heightened risk of abuse and neglect (Cleaver et al 2007) and at higher risk of adverse outcomes.

Given the predominance of families experiencing multiple and complex difficulties who become involved with child protection and the array of social and economic issues that interact with presenting problems such as mental health concerns, family violence and substance abuse, the challenge for child protection is how to provide a holistic and contextual response to the needs of the whole family.

Ultimately such families will be able to make and sustain changes and better meet the needs of their children if service responses, including child protection, address the needs of whole families and where possible assist with the broader systemic factors in which their difficulties are created and situated.

Families presenting with multiple and complex needs comprise the primary client group of modern child protection services and require a whole of family and systemic approach.

The impact of multiple and complex needs

The main challenges for parents experiencing multiple and complex needs are the capacity to care for their children and parent effectively.

Parents are likely to be preoccupied by attempts to deal with and manage pressures, so they are not able to give parenting the attention needed or to parent effectively, and their parenting capacity becomes depleted or compromised. Their parenting may include disengaged, unresponsive, inappropriate, harsh, punitive or abusive responses to children.

Couple relationships may be under extreme pressure and subsequently become conflict-ridden and unstable, and both couples and single parents may lack sufficient family and social supports. Parents' own poor experience of parenting and absence of good parenting models to replicate, may also affect their responses to children and parenting capacity.

To make matters more complicated, family members may be experiencing the same stressors but they present with different reactions, behaviours and problems linked to those stressors and linked to each other's behaviour and problems. For example, a young person's stealing, a father's absence and a mother's depression may all be related to financial hardship.

Over time, the stress, compounding difficulties and cumulative impacts mean that a family can struggle to function, experiencing periodic crises, intensification of individual and family relationship problems, role disintegration or family fragmentation. As family members become increasingly overwhelmed, the effect on individual functioning and on family dynamics can exacerbate contexts in which family violence, substance abuse, mental illness and child abuse occur or escalate (Sutherland and Miller 2012).

Multiple and complex needs and the Children, Youth and Families Act

The *Children, Youth and Families Act (2005)* (CYFA) provides the legislative framework for statutory intervention when a child needs protection.

In considering the issues that may be relevant to children and to families with multiple and complex problems, the following parts of the Act are relevant:

- Section 162 (1) (a)-(f) outlines the grounds for statutory intervention.

You need to consider if the child needs protection or the family requires assistance due to concerns related to abuse or neglect.

- Best interests principles – a child's best interests must always be paramount (s.10).

You need to consider whether the decision-making or action is in the best interests of the child and privileges the child's safety, rights, wellbeing and developmental needs. You also need to consider the child's connection to kith and kin and to community and the child's stability needs.

You must be cognisant of your specific responsibilities in regard to practice with Aboriginal children and families.

- The effects of cumulative patterns of harm on a child's safety and development (s.10 (3) (e)).

You need to consider whether the serious, chronic or unabating nature of the family's difficulties is producing a pattern of cumulative harm for the child.

- That parents must be provided with the 'widest possible assistance' (s.10 (3)(a)).

You need to consider whether sufficient support and assistance has been provided to the family to help them keep their child safe.

The CFYA demands that we think holistically about the child's experience and work in partnership with families. This means that intervention and support for families with multiple and complex needs should be based on the following principles and values:

- **Recognition of the rights of children, with a focus on the interests of children and young people at the heart of the work.**
- **A persistent, supportive and respectful approach in working with families that values and builds on existing strengths.**
- **Parents are acknowledged as having unique knowledge and information about their children and are the primary influence on their development.**
- **Family intervention should focus on a whole-of-family approach.**

A partnership approach between services is also embedded in the best interests principles of the CYFA, necessitating services and professionals to work together in the interests of the child. The Best interests case practice model reflects this partnership approach and collaboration with other services. Arguably, this is most relevant and important in working with families with multiple and complex needs, given the range of difficulties they are experiencing and the likelihood that they are in contact with several agencies or service systems at any given time.

The need for partnership and collaboration across services is critical. Communication, common understandings of roles and responsibilities, planning, coordination and shared language are all important, along with multidisciplinary team and care team processes in providing an integrated multi-system service response. Child-focused services cannot develop effective plans to safeguard children without the involvement of specialist adult-focused services, while individually focused adult services need to attend to their adult clients as parents and consider the impacts of parental difficulties and interventions on children.

A partnership model also involves parents and practitioners engaging and working together, participating in and influencing decision making and valuing each other's knowledge, strengths and expertise. Respect, care, transparency and collaboration should characterise the working relationship. Building partnerships with parents and families in situations of child abuse and neglect is challenging, but skilled child protection practitioners are able to exercise authority and foster cooperation through 'careful, thorough and thoughtful practice' (Turnell & Edwards 1999:32).

How do families come to have multiple and complex needs?

Families with multiple and complex needs are typically situated within a broader context of social, economic and structural disadvantage. Poverty and the interlinked problems of poor health and housing, poor educational and employment opportunities and skills, lack of social capital and family and community supports, crime, mental health difficulties, substance use and violence, early childhood trauma and poor parenting experiences all contribute to social exclusion. The UK government has described social exclusion as ‘joined up problems’ (Social Exclusion Unit 2001), which must be understood as resulting from the interplay of social, historical, trans-generational and cultural factors. Moreover, the disadvantage is multi-directional, occurring as a precursor to and consequence of poverty and isolation.

The constellation of disadvantages associated with social exclusion mirror those present in many families that become involved with the child protection system and constitute common risk factors for child abuse and neglect (Bromfield 2005). It is very important to recognise the significance of parents’ own experiences of trauma and adversity and the impacts this has on them. Adverse or traumatic experiences in childhood coupled with poor or abusive experiences of being parented can produce deleterious individual impacts that compromise functioning and capacity. These individual impacts link with and contribute to social disadvantage and exclusion (Frederick & Goddard 2007) so that individual and social difficulties become inextricably interrelated. Cycles of poverty and disadvantage and patterns of early trauma and adversity commonly produce inter-generational patterns that reflect and repeat the same difficulties.

Child protection practitioners frequently deal with families who have been affected by poverty, social exclusion and trans-generational patterns of disadvantage and with parents who have been profoundly affected by their own experiences of trauma and adverse parenting, which are likely to have compromised their parenting resources and capacities. Given that the problems faced by these families may be chronic, entrenched and interrelated, it makes sense to suggest that ‘joined up’ solutions or systemic responses are called for (Social Exclusion Unit 2001). While it is often not possible for practitioners to directly address poverty and social exclusion, it is possible to advocate for families and to try to provide more holistic responses to family needs, including practical assistance and linking to other resources.

Families with multiple and complex needs and parenting

Parenting

Children and young people require parenting that ensures that they are safe to develop physically and emotionally and that the environment is stable enough to meet their needs (NSW Department of Community Services 2006). There are numerous ways in which parents might create and maintain such an environment and no ‘right’ way. However, parenting must be ‘good enough’ to meet children’s needs. The table below sets out the responsibilities that parents have for their children and illustrates that adequate parenting is more than the absence of violence, abuse or neglect. Good enough parenting requires parents to provide their children with safety, stability, nurturing, comfort, stimulation and opportunities for play, learning and social development.

Parenting Tasks

| Responsibility | What parents have to do and provide |
|----------------------------|--|
| Give physical care | Feeding, shelter, rest, health and protection |
| Give affection | Expressed overt physical and verbal warmth and comfort |
| Give positive regard | Give approval, sensitivity to signals, responsiveness |
| Provide emotional security | Consistent and predictable warmth, sensitivity and comfort |
| Set boundaries | Clear statements on what is acceptable, good supervision |
| Allow room to develop | Provide and allow challenges within the child's capacity |
| Teach social behaviour | Model reliability, reasonableness and assertiveness |
| Help develop skills | Encourage learning and exploration, be responsive in play |
| Help cognitive development | Reading, constructive play, monitor schooling |
| Facilitate social activity | Facilitate peer contact and provide new experiences |

Quinton, D. (2004)

Parenting adaptability

It is now recognised that to carry out the tasks of parenting, parents also need to adapt to changes in a child's needs at any given time and to changes in their environment. This requires problem-solving skills and knowledge of their child's capacities at different ages. Three dimensions underpin parenting adaptability – perceptiveness (awareness of children and their environment, and the impact of their own behaviour), responsiveness (the degree of connection between parents and children), and flexibility (responding appropriately according to the situation) (NSW Department of Community Services 2006).

It is also crucial that parents can hold their children in mind and prioritise the child's needs over the 'wants' that the parent may feel driven to satisfy. The parent's empathy for the child (which can also be described as reflective capacity), is a key factor in assessing risk to the child's safety and wellbeing, and the parent's capacity to keep the child safe (Miller 2011).

Factors that impact on parenting

As discussed previously, it is important to understand that difficulties faced by families with multiple and complex needs are the result of circumstances and events which have built up over time, possibly through several generations of the family.

Critical external social factors that impact on parenting include:

- housing and social environment
- economic status
- unemployment
- educational opportunities.

Family factors that impact on parenting include:

- physical and mental health
- family violence
- other offending behaviour
- disability
- substance use
- levels of family support
- parents' own experience of being parented and experiences of abuse.

Past trauma and parenting capacity

Many parents whose children become involved with the child protection system have their own histories of trauma. This may include physical and sexual abuse, emotional abuse and psychological harm and exposure to violence and/or neglect. Burgeoning research and clinical literature on trauma have demonstrated the severe impact of trauma and persistence of symptoms.

A constellation of symptoms is typically associated with trauma. The widely used Trauma Symptom Inventory developed by Briere (2005) identifies the following acute and chronic post-traumatic symptoms:

- Anxious arousal (for example, anxiety, hyper-vigilance, easily startled).
- Depression (including suicidal thoughts).
- Anger/irritability (in external behaviours and internal cognitions).
- Intrusive experiences (for example, flashbacks, nightmares and intrusive thoughts/memories).
- Defensive avoidance (including cognitive avoidance of traumatic reminders such as denial and thought suppression, and behavioural avoidance of traumatic reminders such as avoiding people, places or situations, or becoming intoxicated).
- Dissociation (depersonalisation, out-of-body experiences and psychic numbing).
- Sexual concerns (sexual distress such as sexual dissatisfaction, sexual dysfunction and unwanted sexual thoughts or feelings).
- Dysfunctional sexual behaviour (sexual behaviour that is dysfunctional, because of its indiscriminate quality, potential for self-harm or inappropriate use to accomplish non-sexual goals, for example as a form of tension reduction).
- Impaired self-reference (problems in the 'self' domain, such as identity confusion, self-other disturbance and a relative lack of self-support).
- Tension reduction behaviour (external methods of reducing internal tension or distress such as self-mutilation or substance use).

When a combination of these and other factors occur, problems become increasingly complex and interrelated and the impacts on individual functioning, parenting, family life and family functioning can be severe.

Research has demonstrated that problems such as family violence, substance abuse and mental illness are frequently interrelated and often occur at the same time.

The evidence: Co-occurrence of multiple and complex problems

Substance abuse has been identified as a common co-morbid condition among people with a severe mental illness (Hegarty 2004), particularly in clinical settings (Hegarty 2004; Stromwall, Larson, Nieri et al 2008). Prevalence estimates of substance abuse issues in mental health settings consistently report rates of more than 25 per cent, with estimates of up to 80 per cent (Todd, Sellman & Robertson 2002) and ‘... figures suggest that as many as three-quarters of all clients with drug and alcohol problems have a dual diagnosis’ (Hegarty 2004: 2).

Adults with learning difficulties are more likely to have mental health concerns (Hudson & Chan 2002), and the rate of mental disorders is two to three times higher in people with intellectual disabilities than in the general population (McGaw, Shaw & Beckley 2007).

Strong associations are also consistently found between family violence and substance misuse, particularly alcohol abuse (Chan 2005, Lipsky & Caetano 2008, Thompson & Kingree 2006), across a range of settings (Klostermann & Fals-Stewart 2006). Alcohol was reported to be involved in 40 per cent of physical or sexual assaults on women within 12 months (ABS, 1996). Alcohol and other drugs may also be used by victims of domestic violence to relieve the physical and emotional pain of abuse (Chan 2005).

Research also shows links between family violence and poor mental health outcomes for victims, with depression (33 per cent) and anxiety (26 per cent) contributing to the burden of disease attributable to intimate partner violence, along with illicit drug use (6 per cent) and alcohol-related problems (6 per cent) (VicHealth 2004b). These findings are consistent with national (Access Economics 2004) and international trends (World Health Organisation 2005).

Considerable correlational evidence links substance misuse with learning difficulties (National Centre on Addiction and Substance Abuse 2000). Exposure in the womb greatly increases the risk of later learning difficulties. Adolescent substance misuse can also lead to learning difficulties, and the risk factors for adolescent substance abuse appear similar to the behavioural effects of learning difficulties – reduced self-esteem, academic difficulties, loneliness and depression (National Centre on Addiction and Substance Abuse 2000). Further studies have also shown associations between learning disabilities and substance abuse in adults (Cosden 1999).

Mental illness, family violence and misuse of alcohol or other drugs impact on individuals and their capacity to parent, especially when these factors coalesce. Where all three factors are present, the risk to children’s safety and their ongoing development can be severe, and these risks and harm are cumulative.

Parenting capacity

Parenting capacity can be defined as:

'The ability of parents or caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to, and to [be able to] adapt to [the child's] changing needs over time. This includes providing for the child's basic physical needs, ensuring their safety, ensuring the child's emotional needs are met and giving a child a sense of being specially valued, promoting the child's intellectual development through encouragement and stimulation, demonstrating and modelling appropriate behaviour and control of emotions and providing a sufficiently stable family environment.'

Department of Health,
Department for Education and Employment, and Home Office 2000

A parent's ability to form adequate and positive attachment relationships with their infants and young children is undoubtedly affected by their own history, circumstances and experiences as well as by the impact of external stresses and pressures. Similarly, a parent's ability to meet a child's ongoing developmental needs appropriately and their ability to care for and respond in helpful ways are affected by their own parents' life events and situation.

Parents affected by mental health difficulties, substance abuse, family violence or their own experiences of abuse and traumatisation are likely to have difficulty understanding and/or responding appropriately to their children's needs. Parental behaviours might include self-preoccupation, emotional unavailability, practical unavailability, frequent separations, irritability, anxiety, distortions of reality, fearfulness, dependency, anger and hostility (Duncan & Reder 2000). Negativity or harsh or ineffective discipline practices are significant consequences of disruptions to parenting capacity (Berg-Neilson 2002).

Furthermore, families with multiple and complex needs are often characterised by parents who have had multiple transitions in their lives. These transitions have left them little time to recover and typically the resources required to aid transitions such as economic wellbeing, emotional security and stability and resilience are not available to these families (Hopson & Adams 1976).

Children in families with complex problems

Many children live in families experiencing multiple and complex needs, with parents who have poor or diminished parenting capacity in the context of mental illness, substance abuse, family violence or disability.

Children growing up in families with complex problems

| | |
|-----------------------|--|
| Family violence | <p>Australian data indicates that more than one-third of Australian women have experienced some form of family violence by a past/current partner. The International Violence Against Women Survey, conducted in 2004, found that young women aged 18 to 24 appear to be at the greatest risk (Mouzos and Makkai 2004).</p> <p>Increasingly, children are being identified and responded to as victims in their own right. According Victorian Police reports, three times as many children were recorded as victims of family violence (2,775 children) in 2009–10 compared with 1999–2000 (Victoria Police 2012).</p> <p>Children are often present at family violence incidents. Victoria Police data for 2010–12 indicates that children were present in more than one-third of incidents attended by police. Younger children are most likely to witness family violence, with children under 6 at higher risk than older children for exposure to family violence (Fantuzzo et al 1997).</p> |
| Mental illness | <p>One in five Australian parents of children up to fourteen years had poor mental health, and six in ten adults with serious chronic mental illness had children under sixteen (Australian Institute of Health and Welfare 2009). Oates (1997) found that one-quarter of female patients newly referred were caring for a child under five, and a similar proportion of adults with a diagnosis of schizophrenia were living in households with children under sixteen.</p> |
| Substance misuse | <p>Some 13 per cent of Australian children aged 12 were exposed to an adult who regularly binge drinks; 2.3 per cent were living with at least one daily cannabis user and 0.8 per cent were living with an adult who uses methamphetamine in the home at least monthly (Dawe, Harnett & Frye 2008).</p> |
| Learning difficulties | <p>The best available estimate, produced by the NSW Department of Community Services (2007), is that 1 to 2 per cent of families with children aged up to 17 include at least one parent with an intellectual disability.</p> |
| Homelessness | <p>Some 12 per cent of homeless people in Australia were aged under 12 (Australian Bureau of Statistics 2006) and 55 per cent of women with children presenting to Supported Accommodation Assistance Program services reported family violence as the main cause of their homelessness (Australian Institute of Health and Welfare 2008a). A recent Australian report revealed that, when analysing the 2004–05 data on homelessness, the largest homeless subgroup of people are children (36 per cent) (Australian Institute of Health and Welfare 2006).</p> |
| Poverty | <p>In 1999, 12 per cent of Australian children were living in relative poverty (that is, income less than half of the national median). This figure placed Australia 14th out of 24 developed nations (UNICEF 2007).</p> |

The impacts of diminished parenting capacity on children

Direct exposure to parental problems can produce negative impacts for children. For example, exposure to parental mental illness can increase risks of developing mental/psychiatric disorders and adjustment difficulties and can contribute to poor intellectual, emotional and social outcomes for children (Smith 2004, Craig 2004). Exposure to parental substance abuse can lead to physical, social and psychological difficulties in children and be manifest in higher rates of depression, anxiety disorders, attention problems and later alcoholism (Beardslee 1998). Children exposed to parental substance abuse are also more likely to suffer neglect and abuse (Lewis & Creighton 1999).

Disruptions to parenting or impaired parenting ability can have less direct or secondary impacts but can also produce profound and significant negative effects for children. The impacts of disruptions to parenting differ according to the age of the child, because the age of children affects vulnerability or resilience to disruptions to parenting and relationships with parents. For babies and young children, negative impacts can include bonding and attachment behaviours, cognition and development.

Attachment and brain development

The bond between an infant and parent/caregiver is critically important to the safety, security and development of the child. Attuned and responsive caregiving promotes optimal physical, psychological, social and emotional development. It also creates the necessary neurobiological foundations to enable the child to manage physiological, emotional and behavioural states and learn patterns for relating to others, while also coming to know trust, love and self-worth (Schorre 2003). In infancy, children rely on parents/caregivers to modulate their physiological arousal through a balance of soothing and stimulation, known as ‘affect attunement’ (Stern 1985). By soothing an infant and responding appropriately, the caregiver enables the child to develop the biological framework for dealing with future stress. Without this, children’s brains do not develop the pathways needed to recognise and understand their own physical and emotional states and they are unable to effectively regulate their thinking and behaviour or learn constructive patterns for relating.

‘The developmental pathway followed by each individual and the extent to which he or she becomes resilient to stressful life events is determined to a very significant degree by the pattern of attachment he or she develops during the early years’ (Bowlby 1988:172, cited Adam, K, Sheldon Keller, A & West M (2000).

Most parents/caregivers can maintain an optimal level of physiological arousal by comforting children in the presence of discomfort, stress or threat (Stern 1985). However, parents who are unresponsive, frightened, frightening or abusive are unlikely to be able to provide attuned and appropriate responses for their children. Their responses may promote chronic hyperarousal, which has enduring effects on children’s ability to think and modulate strong emotions (van der Kolk et al 1996). Fear triggers a stress response involving the release of a cascade of chemicals into the brain to equip us to respond to the stressful situation – this is a normal and functional biological response. However, research shows that if the stress response system is permanently ‘switched on’ – as it can be if children are living with chronic stress – it can damage the developing brain (Shonkoff & Phillips 2001).

When the parent/caregiver (who should be the primary source of safety and protection) becomes a source of danger or harm, attachment difficulties become pronounced, leaving the child in an irresolvable dilemma that can severely disrupt and damage the child's capacity to relate and trust. Attachment difficulties are likely to increase when maltreatment is prolonged. Older children may tolerate more disruption but parental nurture and limit-setting may be adversely affected. It is not uncommon for older children to take on caregiving roles (Sved-Williams & Cowling 2008).

For children growing up with parents who have multiple and complex problems, their needs for secure attachment and developmentally appropriate experiences may be compromised. Adverse effects for children include higher risk of maltreatment, abuse and neglect, and increased risk of attachment difficulties, psychological and emotional disturbance and developmental delay. Moreover, exposure to family violence, parental substance misuse and mental illness can be frightening and traumatising for children.

The impacts of trauma on children and young people

Trauma has its most profound impact during the first decade of life and when experienced interpersonally. It is particularly damaging for children when early experiences of trauma produce physiological and neurological effects and attachment disruption that compromises normal and healthy development. This kind of early trauma is often referred to as 'Developmental trauma' (van der Kolk 2003) because it can harm the child's developing brain and normal development and produce changes in physiology, cognition, affect and behaviour that impair healthy functioning.

Further, it is especially damaging for children when the person inflicting the abuse is also the person entrusted with the child's care and protection and on whom the child is dependent. When trauma is enacted in the context of close relationships, it is often called 'Complex trauma' (Herman 1992) due to the profound and enduring consequences for victims that reverberate, in long-standing ways, across the dimensions of identity, relationships and meaning. Clearly for children who experience early trauma at the hands of a loved one or significant other, the impacts can be severe and harmful.

It is important to appreciate that responses to trauma are highly complex and need to be thoughtfully understood. Some children's responses reflect significant levels of dysregulation where their behaviors and emotions are very disturbed. Other children engage in attempts to manage the physiological arousal and discomfort produced by trauma triggers. Others may respond in ways that enable them to avoid fear, pain and distress. Still others try to control or master other people or their environment to overcome feelings of helplessness and disempowerment.

These reactions commonly reflect victims' attempts to manage trauma symptoms and other distressing responses associated with their abuse – that is, 'attempted solutions' to their confusion and distress. Several writers have pointed to the ways in which victims of prolonged and repeated trauma such as child abuse and family violence accommodate to their situation rather than trying to escape it and develop a range of thinking patterns and behaviours that are directed towards surviving and managing the abuse (Muldaly & Goddard 2006, Summit 1983).

Chronic neglect and cumulative harm in families with multiple and complex needs

For families experiencing multiple and complex needs, entrenched, long-standing and unameliorating difficulties can lead to contexts in which children suffer neglect and cumulative harm. Family violence, parental substance misuse and mental health concerns can and do have a substantial cumulative impact on adults, their parenting capacity and the developmental needs of children, separately and more significantly in combination. When combined, the interactions between these risk factors substantially reduce protective factors and increase risk factors and harmful consequences for children.

Children who are known to child protection are more likely to have parents for whom these risk factors exist in combination rather than on their own. As noted earlier, family violence, substance abuse and mental health problems can affect a parent's skills, perceptions, emotional presence, practical and emotional control, judgement and responses to children. Attachment disruption, experiences of trauma, abuse and neglect and negative developmental consequences for the child are also more likely. In the context of such experiences, a child may develop behavioural and emotional disturbance, including aggression, absconding, violence, and mental health problems that further complicate and diminish a parent's capacity to supervise, monitor and respond effectively to their children, exacerbating unsafe circumstances (Sutherland and Miller 2012).

Cumulative harm refers to the effects of multiple adverse circumstances and events in a child's life. The unremitting daily impact of these experiences can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing (Bromfield & Miller 2010).

It is especially important when working with families experiencing multiple and complex needs that you consider cumulative harm and the impacts of chronic neglect on the children.

(See the *Cumulative harm specialist practice resource*).

It is critical that practitioners understand that neglect can have as deleterious consequences as overt abuse, even though these effects may not be so obvious or direct.

It is also critical to consider from the child's perspective the impacts of chronic *unrelenting exposure or multiple and repeating episodes of exposure to harm*.

Multiple and complex needs and Aboriginal families

Profound and enduring impacts of invasion, colonisation, dispossession, racism and government policies that led to the removal of Aboriginal families and communities from their land and the forced removal of Aboriginal children from their families have produced significant trauma and loss among Australian indigenous peoples (Human Rights and Equal Opportunity Commission 1997). To understand the multiple and complex issues faced by many Aboriginal families today, it is necessary to understand the way in which past events have shaped the experience of Aboriginal people.

There are no Aboriginal people whose lives have not been adversely affected by the past. In Victoria, there are no families who have not lost contact with members of their family or whose family relationships do not still bare the scars of the Stolen Generations or whose families were not decimated by the forced removal to different missions of family members and then the expulsion of lighter skinned family members from the missions. These events happened to people who are alive today.

Victorian Aboriginal Child Care Agency 2006 p. 9

These events have led to profound trauma and loss for Aboriginal families and communities that reverberates across generations and manifests in an array of economic, social, physical, emotional, cultural and spiritual impacts. Aboriginal families and communities face significant levels of social and economic disadvantage, including particular disadvantages associated with poor health, disability and earlier mortality rates. Aboriginal children also experience disadvantages related to their health and education and remain over-represented in the child protection and out-of-home care system.

Many Aboriginal children and families are vulnerable to experiencing multiple and complex needs, which can lead to social, community, family and individual difficulties across generations (Berlyn & Bromfield 2010). However, there is great diversity among Aboriginal people and communities. Some families continue to be profoundly affected by past and current circumstances, but for other families, positive family and cultural connections and a robust sense of cultural identity may have mitigated the impacts of historical dispossession, racism and trauma.

Practitioners need to understand the impact of past experiences, have a knowledge and understanding of key aspects of Aboriginal cultures, values and beliefs and family structures and be open and respectful when joining with Aboriginal families to address problems and concerns.

For practitioners in child protection, it is particularly important to remember that for Aboriginal people, child welfare may invoke fear, distrust and traumatic reminders of removal and displacement. Practitioners must be cognisant of the context that surrounds their practice with Aboriginal children and families and must develop skills and competence in cross-cultural practice. Being guided at each stage of intervention by approaches to practice utilised by Aboriginal child and family welfare organisations and by the consultation and support provided by our partner agency, Aboriginal Child Specialist Advice and Support Service, is important and necessary. Failure to work in culturally safe ways is likely to lead to failure to engage. This lack of engagement may have critical consequences and outcomes for children and families.

(See *Working with Aboriginal Children and Families: A Guide for Child Protection and Family Welfare Workers*, Victorian Aboriginal Child Care Agency 2006).

Multiple and complex needs in culturally and linguistically diverse (CALD) families

A cultural lens needs to be applied to all health and social service care approaches undertaken with CALD families. Culture defines who we are and determines how health is viewed, how children/families develop and how they stay healthy.

Families from CALD backgrounds, and especially those who are newly arrived refugees or humanitarian entrants, may be more vulnerable to experiencing multiple and complex problems. Migrant families may experience isolation, communication difficulties, racist attitudes (Adair 2005), family violence, substance abuse and increased problems related to parenting (Parker 2009). For refugees, the effects of trauma and torture experienced in their country of origin, refugee camps or during their journey to Australia, and the process of seeking asylum has immediate, medium and long-term impacts on the physical and psychological health of parents and children. This can manifest as depression and anxiety, intrusive memories, poor concentration, and/or relationship difficulties (Forum of Australian Services for Survivors of Torture and Trauma, undated).

Practice tool

Families with multiple and complex needs

The aim of this practice tool is to provide specific strategies to guide your work when gathering information, analysing, planning and intervening with children and families with multiple and complex needs.

Approaching work with families with multiple and complex needs

It is important to adopt a whole-of-family approach that acknowledges family strengths and to work collaboratively with other services to address problems and difficulties. This approach is always important to the work of child protection practitioners, but it is particularly applicable to families who present with multiple and complex needs because their difficulties are typically chronic, numerous and inter-related and often inter-generational. The extent and complexity of difficulties can invite parental blame and negativity. Similarly, a narrow focus on risk, episodic protective interventions, and assumptions made out of context about a specific or prominent problem, can obscure the inter-related nature of problems and the need for more systemic analysis and interventions to promote and sustain change.

Adopting a child-focused, family-centred approach

A whole-of-family approach is a useful way of working with families experiencing the most significant and complex difficulties. This approach consists of assessing and addressing the needs of the children, adults and the family and ensuring that support provided to them is coordinated and focused on concerns affecting the whole family.

Collaboration and communication across child-focused and adult-focused services is vital to enable improved understanding, assessment and responses to parental and family issues. Adult services need to be able to view the situation through the lens of the developing child and child services need to have a comprehensive understanding of the parental difficulties to understand how these affect parents' own wellbeing, their parenting capacities and their children.

Child Protection interacts frequently across child-focused services such as family services, child and adolescent mental health services, maternal and child health and schools. However, routine liaison and consultation with adult-focused services on issues such as family violence, drug and alcohol and mental health is also extremely important.

A family-centred approach rather than a problem-centred approach enables child abuse, family violence, mental illness and alcohol and drug abuse to be viewed as inter-related problems, while also demanding services and professionals find integrated ways of working with the whole family.

Strengths-based approach

The term risk is regularly used when discussing families with multiple and complex needs, however, it is important that deficits, problems and difficulties do not come to define families.

A strengths-based approach acknowledges the positive aspects of the family and looks for exceptions to problem-saturated descriptions. A strengths-based approach looks for what parents and children do despite problems, how they have tried to overcome their problems, what they do well and explores their aspirations and hopes.

This approach consists of practitioners emphasising protective factors, assets and strengths. This has the effect of:

- building engagement and communicating respect
- communicating a sense of hope and competence
- providing a contextual explanation of presenting problems rather than individual blame
- encouraging expectations for improvement and change
- ensuring a focus on what has happened to the family rather than on what's wrong with the family.

This approach is transparent and does not avoid difficult conversations about discrepancies in family member's accounts of events. It is informed about child abuse and offending behaviour and is not naïve about the dangerous circumstances some children experience (Best Interests case practice model, summary guide, 2008).

It is important to take all risks to children's positive outcomes and wellbeing very seriously. Safeguarding children and vulnerable adults must be paramount (Children's Workforce Development Council 2010).

A multi-service system response

Given the range of issues facing families with multiple and complex needs, an integrated, multi-service response is preferable to sequential or parallel interventions. To achieve desirable outcomes for children, a shift from a compartmentalised focus on risk to a more holistic view of family experience is necessary.

Difficulties can exist in working across multiple service sectors due to different service roles, frameworks for practice, different language and models of intervention and service delivery constraints. Given the differences across agencies and the potential for conflict or inadequate communication and collaboration (Scott 2005), it is important that agencies work diligently to strengthen their partnerships and to resolve any disputes that arise. Seek support to have externally facilitated meetings if the normal processes remain stuck.

A collaborative approach – the importance of family meetings, professionals' meetings and care teams

Given the need for partnership between families and services to address increasingly complex presentations of families, *family group meetings*, *professionals' meetings* and *care teams* are important processes, ensuring a holistic, multi-service system, child-focused, family-centred approach that works together on the child and family needs.

Family meetings enable family and extended family members to generate ideas and desired outcomes, ensuring the needs and best interests of the child are met while supporting the parents and family.

Professionals' meetings enable key services and workers to establish and facilitate working relationships, develop clarity on service roles, mandates and responsibilities, develop a shared and comprehensive understanding of the child and family, and clarify any points of difference that may impact on practice.

Care teams, which include parents, carers and professionals involved in the life of a specific child and family, are particularly valuable. These teams meet regularly to share information, knowledge and understanding, and participate in formulating goals, plans and interventions that are important and necessary to ensure the safety and wellbeing of the child and to support parents and families in achieving positive change.

The Care team process aims to build relationships between and across services and between the parents and key services. This process develops agreed goals and objectives, enables plans to be put into practice, provides support for parents and opportunities to review progress and outcomes.

Research has shown that systemic failures occur not because the information was not known about the dangerous indicators of fatal abuse and neglect, but rather agencies and professionals did not share the information or communicate adequately about the significance of the details or jointly plan a coordinated response (Munro 2005).

Information gathering

At the beginning of your involvement, it is important to gather a comprehensive and detailed picture of the family, its history and current circumstances and the impacts of those circumstances on the safety and wellbeing of children. In so doing, practitioners will be able to build a contextual understanding of the family that promotes respectful and empathic practice and avoids responding in a compartmentalised manner to multiple and interlinked family problems. As the case progresses, existing information will need to be updated and new information sought and incorporated into the intervention plan.

Engaging parents

Effective engagement is crucial to work with families with multiple and complex needs. Many of these families have a history of non-engagement and have often actively disengaged or rejected previous support. It is helpful to reflect on the barriers to engagement so you will be equipped with some ideas about what to avoid.

Barriers to engagement may be have been caused by:

- Services previously treating families' problems in isolation, leaving the family overwhelmed by other needs.
- Families feeling powerless and helpless and be daunted by how services present.
- Families having unidentified or unarticulated needs that have prevented engagement (for example, prior experiences with welfare agencies, mental health or learning disabilities).
- Families having been unable to acknowledge the impact of their needs and behaviour on children.
- Previous support not being sustained for long enough, so the family regressed when support stopped, making re-engagement difficult.
- Practitioners not having the skills and qualities necessary to engage families, seeing them as too complex and challenging or not using culturally appropriate approaches (Fenelon 2011).

Parents and children's openness to engaging with services may be affected by their experiences with formal services and supports. For example, in an Australian study, barriers and disincentives to parents accessing services included experiences of feeling discriminated against or treated unequally due to their situation, feeling humiliated and embarrassed by their circumstances and fearful their children would be removed, being judged as not needy enough or not meeting set criteria, and that it was up to them to make contact with the right person the first time (McArthur, Thompson, Winkworth & Butler 2009). Another small study of 20 very isolated parents found that parents lacked the social networks needed to help introduce them to services. The small but significant group that resisted all formal services indicated that it is most likely to be assisted in everyday environments that are normal and non-stigmatising, rather than through formal agency settings (Winkworth, McArthur, Layton, Thomson & Wilson 2010).

In thinking about family engagement, it is useful to hypothesise about barriers to engagement or potential barriers to engagement before you begin work. This will enable you to carefully consider how you position yourself and the work that needs to be undertaken and give it the best chance of success. If family members have felt hopeless or blamed and this has compromised engagement with services, it will be critical for you to offer optimism and respect in the preliminary engagement phase and as the work progresses. You will need to help them overcome the barriers to engagement.

Think carefully about how you are going to engage the family. Effective engagement will require you to first consider the potential barriers to engagement. In thinking about the family's experience, you can begin to build a trusting relationship with all family members and position the work in a way that is most likely to result in the meaningful engagement of family members.

Building a relationship with the family

The most important foundation of family intervention is to make a connection between the key practitioner and the family. This includes all family members and may also include extended family and other people within the family circle. This initial connection will create the context for ongoing assessment and intervention. In making this initial connection, it is essential that the practitioner displays reliability, consistency, warmth and responsiveness from the outset.

When seeking to build rapport with a family, it is important for practitioners to demonstrate:

- unconditional *positive regard*, which involves taking a respectful stance and suspending judgement
- *emotional literacy*, which involves being attuned to and managing your own emotional responses, and recognising and managing the emotions of others
- *communication skills*, which involve the use of techniques to improve connection, understanding and engagement.

Joining with the family

Planning a first visit to the family is a useful tool in family engagement. A planned visit should provide a conceptual map to help the process and content of the meeting. Knowing what needs to be covered and having a tentative plan for how this might be undertaken can alleviate practitioner anxiety and contribute to more effective engagement. For example, knowing that it will be necessary to establish the purpose of the visit and to clarify your role and responsibilities as a practitioner can be complemented by a warm and calm approach and by noticing and affirming visible positives.

Refer to the child and family snapshot tool which will enable you to join with the family in gathering information.

Tips for engaging parents

Engagement with parents can be facilitated by:

- Clearly explaining your role and purpose.
- Being courteous and respectful at all times, even in the face of parental anger, hostility, frustration or disinterest. These are responses that need to be understood and worked through, often before information gathering and assessment has begun. The practitioner needs to be interested in hearing about these feelings and it is helpful to acknowledge and empathise with them.
- Look for opportunities to join the parents through empathic responses to their reactions. For example, ‘... that must have taken every bit of strength you had to survive at that time ... how would you rate what we’re dealing with now to what you went through back then?’ ‘It sounds like you’ve been stuck between a rock and a hard place.’ ‘I’m so sorry that people didn’t get back to you or organise the respite care you were expecting last year – that must have been very frustrating. As I’m your new practitioner, I’ll make sure I follow that up ... is that something that you’d find helpful now?’
- Be curious about and actively seek information from the family about their experience – take the time to listen carefully to their story and be attentive to detail. ‘So when your dad left, you were only eight and your mum had four other little ones younger than you ...’
- Listen and then listen some more. Paraphrase so that they know you are listening to them and be genuine in your interest and concern. For example, ‘I might have this wrong but is it okay to check out that I’m understanding what happened last night? You were late home from the hospital and ...’
- In the information gathering process, do not be afraid to comment on family strengths in the context of difficulties. For example, ‘With all this going on, how have you managed to get the baby bathed and dressed this morning and to be even able to concentrate on our conversation?’ Make sure that you tie your positive observations to genuine aspects of the family’s life. If the house is a mess, notice the beautiful baby photo or that they had cereal for breakfast (a good thing), that the baby wants a cuddle from them or is giving you a great smile.
- Find something that is neutral such as the football or a popular TV show so that you build an easy rapport. Getting to know the family and finding ways to connect with them conveys that you are someone that is down to earth and able to help people relax. If you can help families to lower their defences and trust you, the quality of your information gathering will be much stronger, your assessment will be much better and the family will be much more likely to work with you on the issues rather than get into a battle.
- Be clear and honest with the family about the bottom lines, but do so in a manner that is not cold and or indicative of a ‘power over’ stance. We want to ‘work with’ families and empower them to be the parents the children need to have.
- Try to join them in a collaborative endeavour that is focused on the children and family’s identified needs (Sutherland and Miller 2012).

Remember the most constructive path to addressing, intervening and resolving child and family concerns and difficulties is through a respectful and collaborative working relationship with parents or carers. This begins from the first exchange you have and continues through the length of your involvement. Engagement is a process not an event.

McArthur et al (2009) found that practitioners who engaged effectively with families:

- treated family members with respect and courtesy
- focused on building the family's strengths
- promoted positive relationships among parents and children
- developed trust through sensitive and inclusive inquiry about their circumstances
- took an active, caring, whole-of-family approach to their situation
- linked with other relevant services and worked together to avoid conflicting requirements and processes
- focused on the children's needs
- maintained a continuous relationship with the family – without creating dependence.

In view of recent research, it is also important to help build parental social networks and non-professional parenting supports.

Undertaking a comprehensive family assessment: being alert to multiple and complex problems

Comprehensive assessment of the whole family is central to successful intervention and support. The goal of assessment is to develop a sophisticated understanding of the family's functioning, gain an understanding of the factors affecting the family and their needs, develop partnerships and prepare for intervention if necessary. Undertaking a comprehensive family assessment is the first step in the information-gathering process. This assessment should involve a gradual and sensitive exploration with the family about their:

- (i) history and prior experiences
- (ii) current circumstances and needs
- (iii) future protective and risk factors.

It is helpful to construct a genogram to gain a clear picture of the family members and to create a focal point for discussing family relationships, significant life events, developmental stages, losses and traumatic events and relevant patterns or themes across the life of the family. (See the child and family snapshot practitioner field tool to help you construct a genogram).

It is also helpful to construct an eco map to enable a visual representation of key social and community links and supports relevant to the family.

In undertaking the family assessment, it is important to seek the perspectives of all family members, because this enhances engagement and may provide additional information and alternate perspectives and views.

Information about the following is particularly important for the family assessment:

- Each parent's own family of origin, their experience growing up in their family, the way in which they were parented and the nature of family relationships. The presence of family violence, sexual or physical abuse, child abuse and neglect, mental illness and other experience of trauma or disadvantage in the parent's own experience is likely to affect their parenting and perhaps their own wellbeing and functioning.
- The family history and current circumstances including health, employment, housing, education, informal and formal supports, extended family and significant others, the status of relationships (single mother, separated, contact between parents or not), dynamics of the couple relationship including power and gender, and the presence of current concerns pertaining to substance use, family violence, mental health concerns, and cultural or other factors impacting parental or family functioning.
- The developmental stages of children, the parents' understanding of children's needs and ability to prioritise their children's needs, the relationship between the parents and each child, the relationships between siblings, the child/children's health, emotional, behavioural, social and educational development, the child's connection with the primary caregiver, family, extended family, school, community, culture and any potential sources of harm to the child.
- The parents' attitude to their child/children, capacity to meet child needs and to ensure safety, stability and opportunities for optimal development, any history of abuse, neglect or patterns of harm, parental family of origin experiences.

(Sutherland and Miller 2012)

In gathering this information from families, practitioners are encouraged to notice strengths and achievements, comment on successes, empathise with difficulties or problems and help parents put their current problems into context. In so doing, parents can be supported to identify the concerns they want to address and the changes they want to make.

Practitioners also need to seek information from other professionals and services that have had involvement with family members in the past or present and utilise this information in developing the comprehensive family assessment.

The information obtained will help the practitioner gain a clearer sense of the resources and competencies of the family, as well as the areas of difficulty and concern. It will also help in developing a picture of the degree and severity of the areas of difficulty and the likely impacts for parents and children. Because the assessment process will enable family members to identify and analyse their experience, assessment itself is often an intervention. The development of self-awareness and taking a family through the process of critical reflection on their environment can strengthen engagement and provide motivation for change (Sutherland 2011).

Gathering and exchanging information with Aboriginal families

In undertaking a family assessment with an Aboriginal family, it is important that information gathering is conducted in a culturally aware and sensitive manner. Utilise the knowledge, advice and skills of the Aboriginal Child Specialist Advice and Support Service (ACSASS) practitioner to plan the visit to the family and be guided about the appropriate manner of gathering information and tabling concerns. Be alert to cultural differences in relation to definitions of family, identity, child-rearing practices and values and beliefs. Be particularly cognisant that contact with 'welfare services' may invoke anger, fear, deep distrust and traumatic reminders of removal and displacement and 'complicated grief' (McDermott 2008). It is necessary to be guided by approaches to practice utilised by Aboriginal child and family welfare organisations and by culturally informed consultation and support at each stage of intervention. Failure to work in culturally safe ways is likely to lead to failure to engage the parents and family members.

It is very important that you are sensitive to Aboriginal individuals' micro and macro experiences with welfare agencies, observing how their thoughts and feelings regarding these experiences are translated into perceptions and actions.

Some Do's and Don'ts

| ✓ DO | ✗ DON'T |
|---|--|
| ✓ Obtain prior knowledge of the Aboriginal person | ✗ Allow stereotypes to affect perceptions |
| ✓ Build a rapport with the Aboriginal person | ✗ Use terms such as 'half caste' and 'full blood' |
| ✓ Use simple and straightforward language | ✗ Use jargon, professional or bureaucratic language |
| ✓ Be mindful of eye contact | ✗ Assume inattentiveness or avoidance |
| ✓ Understand periods of silence | ✗ Assume the person has nothing to say. Be patient. Periods of silence are common in conversations with Aboriginal people. |
| ✓ Involve Aboriginal colleagues to help and guide you | ✗ Stick to well constructed questions; elicit a narrative response (Fenelon 2011) |

Assessing parenting capacity

A comprehensive assessment should reveal why parents are struggling to meet their children's needs. Effective engagement of parents involves working together to explain and understand the factors that are getting in the way of more appropriate and effective parenting. Family assessment involves family members identifying and analysing their own experiences, so it can be a useful intervention, enabling family members to become aware of the impacts of their behaviour and circumstances on others in the family. Refer to the **family snapshot** within the practitioner field tool for help (available at <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers>)

Together with the family you should be able to build a clear picture of the following:

- What problems are being experienced?
- Which are the main problems contributing to the parent's current circumstances?
- Is there a context of disadvantage and exclusion that might be compounding the problems?
- Are there other problems or barriers to the parents' ability to deal with their problems?
- How are the problems being experienced by the parents related to each other?
For example, is a parent's substance use linked to his/her current or previous experience of family violence? Is the family's lack of money and transport preventing it from accessing support?
- What are the impacts of these problems on parenting?
- What were the parents' own experiences of being parented?
- Does the parent have a history of abuse or neglect? What is the parents' view or attitude towards their experience of abuse? Do they normalise or minimise it? Are they still deeply troubled, affected, distracted or traumatised by their own history? Are there any symptoms of trauma that might have debilitating effects on parenting?
- Can the parent prioritise the child's needs and parent-child interactions?
- Can the parent provide an environment in which the child's physical, emotional, cognitive, social and educational development is facilitated?
- What is the parent's attitude towards the child? What are the parent's beliefs about the child? Is the parent warm and responsive to the child?
- What strengths can the parent/family build on? Responses within families are diverse and some can create supportive and nurturing environments despite parental problems. What are the strengths that the family can build on? You might need to start small, such as recognising the parents' love for their children and desire for them to be happy and well, even when parents themselves cannot meet their children's needs.
- Are the family support networks, or lack thereof, a source of strength or stress?
- What kind of relationship does the parent have with friends and extended family? Are the parents' social networks making it hard for parents to change? For example, do their friends also have substance addictions? Are the parents isolated? Are their family and friends a potential source of support?

Where parental problems are the pressing concern, practitioners often focus on assessing the capacity of the parents and the factors affecting their ability to effectively parent. In so doing, the experience of the child can be inadvertently overlooked. As such, it is necessary to see and talk with children, noting any discrepancies between the parents' account of the child and the child's functioning or presentation. If the child is an infant, carefully observe the relationship with his/her parents and siblings (Jordan, Sketchley, Bromfield & Miller 2010). Refer to the Infants and their families specialist practice resource for further guidance in this area. If the child is older, engage him/her to explain his/her view of the family circumstances and family relationships.

A critical component of any assessment of parenting capacity is gathering information about the effects of parental and family problems on the child. Practitioners need to make sure that observations and interviews of children form part of their information gathering.

For further tips on communicating with children, see the *Children and their families specialist practice resource* (Robinson, Miller, Price-Robertson, & Carrington 2012). Refer to the **child snapshot** within the practitioner field tool to support your work (available at <http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers>)

Assessing parenting capacity in Aboriginal and CALD families

Parenting practices are not universal and practitioners must be careful not to impose their own cultural practices, values, and beliefs about parenting onto families with whom they are working. Your role is to assess whether children are safe from harm and are receiving the physical care, affection and emotional security they need.

It is critical that you do not assume culture is a risk factor – connection to culture and community is protective for children. For example, culture and the maintenance of culture is central to healthy infant development and identity formation in Aboriginal communities. Aboriginal children know who they are according to how they relate to their family, community and land (Victorian Government Department of Human Services 2008). Practitioners will need to assess whether, in the present circumstances, traditional, cultural parenting practices are contributing to the child's safety and wellbeing, or whether there are circumstances that put the child at risk of harm and neglect.

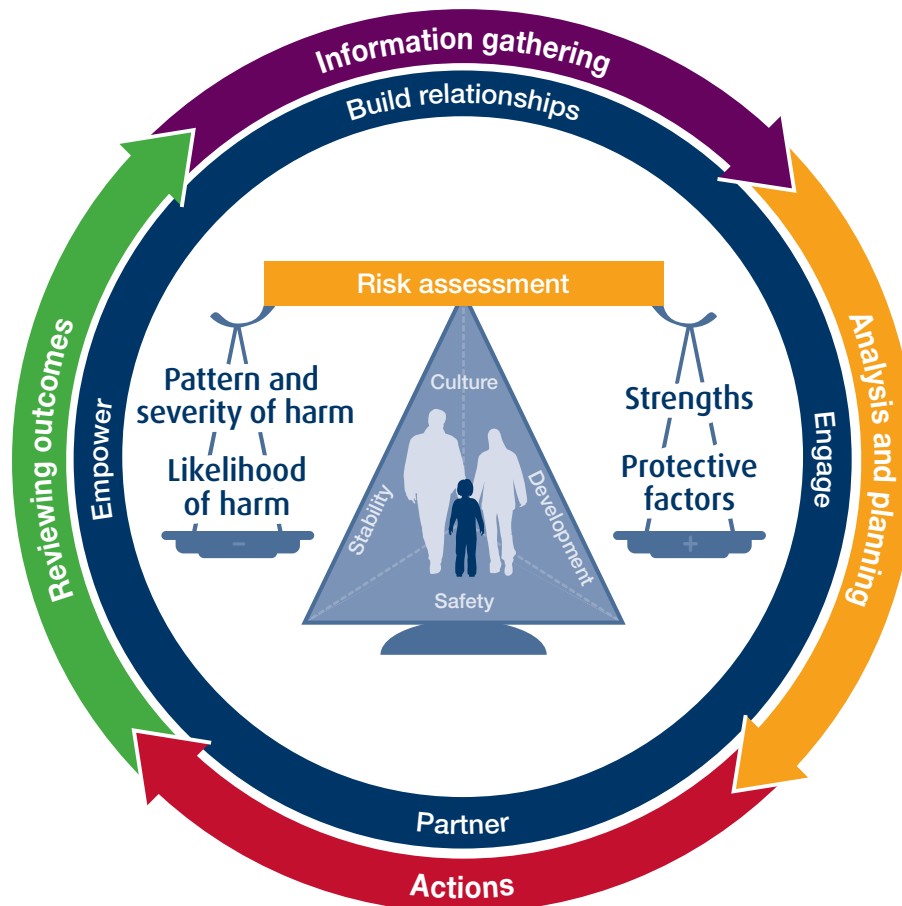
- Be aware that culture and parenting practices are not homogenous and can vary across families, communities and geographic areas. Practitioners will need to determine which practices are applied in the family they are working with (Neckoway, Brownlee & Castellan undated).
- When working with Aboriginal children, child protection practitioners need to involve an Aboriginal Child Specialist Advice Support Service practitioner in making the assessment and planning the intervention.

Practitioners can also consult Section 12 of the CYFA for guidance on working with Aboriginal families, and Section 11(g)-(i) for guidance on working with families from culturally diverse backgrounds.

Impacts of common parenting problems

To inform your understanding of the impacts of common parenting problems on children and help your analysis and planning, Impact Tables are provided in this guide that bring together the key research in relation to the impacts of common parenting problems. The Impact Tables, situated in the Appendix, page 58, examine individual impacts, parenting impacts and the risks of abuse and neglect associated with family violence, substance use, mental health issues, learning difficulties and acquired brain injury.

Analysis and planning



Risk assessment

To formulate a risk assessment, you need to be a critical thinker and to consider multiple competing needs, prioritising the child's safety and development. Careful attention needs to be given to the balance of risk and protective factors, strengths and difficulties in the family. Your assessment needs to be forensically astute; and you should consider all sources of information such as observation, previous assessments, advice from all significant people and professionals. Do not rely on phone assessments or parental self report where there are suspicions of non-accidental injury, or where there have been previous concerns or offending behaviour.

Synthesise the information you have gathered about the current context and the pattern and history; and weigh the risk of harm, against the protective factors. Keep in mind that the parents' desire to change dangerous or neglectful behaviours does not equal the capacity to change; and that strengths and protective factors need to be sustained over time. The best predictor of future behaviour is past behaviour. Hold in mind the urgency of the child's timeframes for safety and secure attachment relationships. Imagine the child's experience of cumulative harm. Remember, other than the family's characteristics, the quality of the relationship you form with the family is the single most important factor contributing to successful outcomes for the child.

Characteristics to consider when assessing risk

Based on examination of file records and other data relating to over 1500 children, Reid et al (1995) identified three important organising principles consistently associated with occurrences or recurrences of child abuse or neglect for children:

1. The first and most important dimension of caregivers' characteristics that should be considered, is their prior pattern with respect to the treatment of children. The number of maltreatment events they have initiated, their severity and recency are the most basic of guides to future behaviour. In the absence of effective intervention these behaviour patterns would be expected to continue into the future.
2. If an individual believes that they are correct in their opinions about children, they will attempt to continue their behaviour so long as they are not prevented from doing so.
3. The third dimension concerns the presence of 'complicating factors', most significantly, substance abuse, mental illness, violent behaviour, and social isolation. The relevance of complicating factors is the extent to which they, singularly or in combination, diminish the capacity to provide sufficient care and protection to the child or young person.

The Best interests case practice model is underpinned by a strengths based approach that assesses the risks, whilst building on the protective factors to increase the child's safety.

Attention to safety factors within the risk analysis recognises that:

1. Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management
2. Strengths which increase the potential for safety are evident in even the worst case scenarios and these are fundamental building blocks for change
3. A constructive approach to building safety can be taken which may be different to efforts to minimise harm
4. A strengths perspective can be actively (and safely) incorporated into what may otherwise become a 'problem saturated' approach to risk assessment and risk management

(cf. Turnell and Edwards, 1999)

Current risk assessment

Current risk assessment highlights the fact that it is made at a *point in time* and it is therefore limited and will require modification as further information comes to light. Your risk assessment should address the following key questions: Is this child/young person safe? How is this child/young person developing?

1. Given all the information you have gathered, how do you make sense of it?
Consider the **vulnerability** of the child and the **severity** of the harm:
 - What harm has happened to this child in the past?
 - What is happening to this child now?
2. What is the **likelihood** of the child being harmed in the future if nothing changes?
Hold in mind the **strengths and protective factors** for the child and family.
3. What is the **impact** on this child's safety and development, of the harm that has occurred, or is likely to occur?
4. Can the parents hold the child in mind and prioritise the child's safety and developmental needs over their own wants and constraints?
5. From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children?
6. If the circumstances were improved within the family, what would you notice was different – what would there be more of? What would there be less of? Who would notice?

Having undertaken a comprehensive family assessment developed with information gathered from family members, professionals and agencies and relevant records, you will be in a position to identify the needs and difficulties being experienced by the family and to analyse whether these impact parenting capacity.

Knowing the types of problems parents are experiencing (such as substance addiction and mental health issues) is important because it alerts you to the types of impacts to look for. But naming these problems is not a parenting assessment. An assessment of parenting capacity requires you to analyse and articulate how the problems and strengths in this family affect the parent-child relationship and result in children's parenting and safety needs being met or unmet.

Case example

Cassie is a mother of five children aged fifteen, thirteen, eight, six and four. Cassie, 43, has been suffering from a serious eating disorder for many years in the context of her own history of severe physical and sexual abuse. She has managed to care adequately for her children but more recently due to her declining physical condition, she has required hospitalisation for extended periods. Consequently her parenting capacity has been diminished and disrupted. In addition, Cassie has recently separated from her husband who was also psychologically and sexually abusive and he no longer has contact with the children. Cassie has no extended family members on whom she can rely to safely care for her children. The two older children feel very burdened by the impacts of their mother's physical and mental health concerns and the younger children all suffer from disabilities. Cassie is well engaged with her mental health worker and other key services. She has a very positive relationship with the children's current carers and loves and enjoys her children.

Utilising the above case example, we can map out the family's strengths and risk factors as follows:

| Area of family life | Strength or protective factor | Risk factor or area for change |
|------------------------|--|--|
| Health | Mother well engaged with medical and mental health services and supports. Has a key mental health worker. | Mother has significant physical and mental health concerns. Younger three children have developmental disabilities. Older two children have emotional wellbeing concerns. |
| Family history | | Mother has history of abuse and trauma and abusive parenting. |
| Extended family | | Limited options for support as maternal and paternal family pose risks. |
| Housing | Mother has stable rental housing, well suited to young children. Good play areas. | |
| Relationships | Warm, close parent/child relationships. Positive and attached sibling relationships. Daily routines, structures, positive communication. | Children's father has alcohol abuse and mental health concerns, has been abusive of their mother. |
| Education and learning | Children attend school and pre-school. Specific supports in place for younger children in relation to disabilities. | |
| Child factors | Strong sibling attachments. No evident behavioural difficulties. | Concerns regarding older two siblings in regard to the emotional and practical burden resulting from mother's illness. Disabilities and developmental delay for the three youngest. |
| Social factors | | Financial difficulties. Few informal social or community supports. |

| Area of family life | Strength or protective factor | Risk factor or area for change |
|---------------------|---|--|
| Support services | School, kindergarten, childcare, mental health, hospital, family counsellor, early intervention services, children's carers. | Lack of extended family and community connections. Reliance on professionals/formal supports. |
| Parenting capacity | <p>Positive parent/child interactions, relationships, physical safety, adequate care, love, affection, opportunities for play, learning and development.</p> <p>Mother making progress in addressing concerns.</p> <p>Father's offending behaviour limited since mother separated from him.</p> | <p>Diminished parenting capacity due to maternal ill-health.</p> <p>Disrupted parenting due to mother's hospitalisations and children placed in out-of-home care.</p> <p>Emotional and developmental impacts on children.</p> <p>Long and extended history of mother's physical and mental health concerns poses concern in relation to cumulative emotional and developmental impacts for children.</p> <p>Concerns regarding the father's potential to demand access to the children and their fear of him. Eldest son wants to see him.</p> |

The above case example illustrates the importance of clearly identifying the problems being experienced by the family and locating them within the broader family context to enable a fuller view of family strengths and risk factors. From this vantage point, an assessment of the impacts of the problems and difficulties on children and on parenting capacity can be further explored.

Your analysis of the information gathered should enable you to articulate:

- Which aspects of parenting have been affected (such as nutrition and hygiene, emotional responsiveness, physical protection, provision of basic needs for care, clothing and shelter, cognitive stimulation, positive childhood experiences).
- How the problems and strengths in the family are affecting the children's safety, developmental and parenting needs.
- How problems may be inter-related, mutually reinforcing or generating further difficulties.
- How the child is or might be at risk of abuse and neglect as a result of the parental and family problems.

When is parenting abusive or neglectful?

As discussed earlier, optimal or effective parenting requires parents to be warm, supportive, sensitive and responsive to their child's needs, emotionally expressive, effective in providing discipline and ultimately be able to optimise their child's development (NSW Department of Community Services 2006). Not all parents are able to provide optimal parenting and not all parents can provide optimal parenting all the time. Parenting can be difficult and stressful and it is normal to need help sometimes. Provided parenting is adequate, sometimes referred to as 'good enough', in meeting children's overall needs, there is no need for formal or statutory intervention. However, if parenting is abusive or neglectful or parenting capacity is so diminished that children's safety, stability and developmental needs are put at significant risk, intervention to protect the child is necessary.

Assessing parenting capacity – focusing on the child's experience

A key component of any assessment of parenting capacity is a focus on the child's experience. Your assessment needs to be consolidated by attending to the child, the impacts of parental problems on the child and the effects and consequences of poor parenting capacity for the child.

What are children's daily experiences?

Parents may minimise or underestimate the impact of their problems on their children, assuming that children have a limited awareness or understanding of the problem. However, research with children has shown that they know earlier in greater detail about their parents' problems than their parents believed (Dawe, Frye, Best, et al 2007, Gorin 2004, Humphreys, Houghton & Ellis 2008, Mullender, Hague, Imam, Kelly, Malos, & Regan 2002). Gorin (2004) suggested that the average age at which children became aware of their parents' problems was between four and five years. Interviews with children have shown that they were able to form an accurate picture of what was happening in the household, despite parents' attempts to shield them (Dawe et al 2007, Gorin 2004, Mullender et al 2002), particularly as problems escalate and parents become less able to plan, control or hide the situation.

Research with children has shown that they know earlier and in greater detail about their parents' problems than their parents believed (average age of awareness is 4 to 5 years).

Children can be reluctant to reveal their knowledge for multiple reasons, including:

- believing it is not their place to say anything
- concern for the parent
- having been rebuffed previously
- being fearful and misattributing the cause of problems to themselves.

Parents' attempts at concealment may cause children to feel unwanted or rejected or increase children's fear. Concealment can also create a culture of secrecy, preventing children from talking to parents or seeking support in relation to other victimisation they are experiencing (such as sexual abuse) (Dawe et al 2007, Gorin 2004, Mullender et al 2002).

It is vital that you observe and engage children when undertaking your assessment of parenting capacity. Children can give you a unique perspective on how parental problems affect their daily lives. Ask yourself questions such as:

- Do the children appear to be healthy overall?
- Are basic hygiene and nutritional needs being met?
- Are the children displaying any symptoms of trauma?
- Do the children appear to be developmentally 'on track'? For instance, are their language and social skills age-appropriate?
- Do the children get involved in play activities or do they seem disconnected and prefer to be/play alone?
- Are the children's emotional responses appropriate for the situation?
- What do the children do when in need of comfort? Who do they turn to?
- Do the children seem to be anxious or wary of other people – their parents, other children or strangers?
- Do the older children appear to be carrying out some parental functions, such as caring for younger siblings, taking on household tasks?
- What are the children's routines? Who looks after them?
- Who lives in their house? Who comes to visit? What are their neighbours like?
- What do the children worry about?
- What do their parents worry about?
- What makes/would make the children happy?
- What do the children know or understand of their family's situation?
- With what do they think they and their parents might need help?
- Do the children feel safe?
- Who are the significant adults in their life?

Children growing up in households where their parents are struggling to cope with multiple and complex problems may not be having their physical and emotional needs met. They may be experiencing adverse developmental impacts, attachment difficulties or be displaying symptoms of trauma. Use your observations of the children and the responses provided by the children to inform your assessment.

It is important to understand the problems facing parents and to empathise with their situation. Equally, it is essential that the impacts of parental difficulties and impaired or diminished parenting capacity be acknowledged and that careful and comprehensive consideration is given to the impacts on children. Your first responsibility is to the children. However, you are usually better able to discharge your responsibility to the children by effectively engaging with their parent(s).

Refer to the Impact Tables (page 58) to help you recognise the impacts of parental problems on parenting and the potential risks to children.

Analysing information from multiple sources

Practitioners need to gather information from multiple sources to form an accurate assessment of the family. Any professional opinion is of itself limited by the time, role and focus of the practitioner (for instance, the maternal and child health nurse who sees an infant only for brief periods once a fortnight, or the drug and alcohol practitioner who is focused on the adult's recovery, not his/her parenting capacity). Parents and extended family and other key people in the child's life are experts about their family and their children. However, professional knowledge is also necessary and valuable. Ask yourself these questions:

- Have you considered a family decision-making meeting to canvass information and support from wider family?
- Have you spoken to other professionals and services involved with the family?
- Have you considered holding an early case conference or professionals' meeting?
- Is the child or young person an Aboriginal or Torres Strait Islander? If so, what is the Aboriginal Child Specialist Advice Support Service/Lakidjeka practitioner's perspective on the child's safety, stability and development?
- Have you consulted with other cultural services if appropriate?
- How have other service systems intervened in the life of the family? What has been the involvement of police, adult-focused services such as drug and alcohol, mental health, homelessness, family violence and sexual assault services? What knowledge and information do they have about the family?
- Think broadly about family and the significant people for the child. Have you considered a family decision-making meeting?

When gathering information from other professionals involved with treating or responding to the parent's substance use, learning difficulty, mental health issues or violent behaviour, ask directly about the potential or actual impact on the child.

Aboriginal children and families

Child protection practitioners must involve an Aboriginal Child Specialist Advice Support Service practitioner in all stages of their involvement with Aboriginal children and families. The ACSASS practitioner will provide critical advice and guidance in gathering information and in assessing and analysing information and planning interventions.

Families with multiple and complex needs and cumulative harm

Children are particularly vulnerable to cumulative harm in families with multiple and complex needs in which the unremitting daily impact of multiple adverse circumstances and events have a profound and exponential impact on the child, and diminish their sense of safety, stability and wellbeing (Bromfield & Miller 2007).

You should take the following steps:

- Summarise the file according to type, frequency, severity, source of harm and duration.
- Identify what has been the previous involvement of your service with the children, their siblings and their parents? Analyse what did and did not work and do not repeat the same intervention plan if it has been unsuccessful before.
- Incorporate the history you are able to collect from other services and professionals who have been involved with the family.
- Note the number of contacts or reports that your agency has had in regard to the child or family, because this can be an equally important measure of concern as the details of each report.
- Be alert to multiple interlinked problems, an absence of protective factors, social isolation and enduring parental problems such as low income, poor education and work experience, social and financial difficulties, family violence, drug or alcohol abuse, mental illness and emotional or behavioural problems of a child/children the parents cannot control (Loman 2006).
- Do not underestimate the negative effects of environmental concerns and neglect. Although these may appear 'low impact' harms, the cumulative effects are extremely deleterious to children.

The short and long-term effects matter:

- What has been the impact on the child to date?
- What are the likely outcomes for the children should their circumstances remain unchanged?

For guidance on recognising, assessing and responding to cumulative harm, see the [Cumulative harm specialist practice resource](#).

Sourcing a specialist assessment

A comprehensive and thoughtful analysis of the factors affecting parenting capacity can in most cases produce a relatively clear picture of the current impacts and the likely future effects on the children. In some cases, however, critical information is unavailable, parenting quality is uncertain, or complex couple or family dynamics complicate the picture. Sometimes the presence of multiple and complex or inter-related problems makes analysis and decision-making more complex.

In these cases, it is important to consider a specialist assessment of parenting capacity to be conducted by a clinically skilled and qualified practitioner. A specialist parenting capacity assessment can include psychological testing, clinical interviews of parents and clinically focused observations of parent/child interactions. A formal assessment report should then be provided by the specialist and used to inform further decision-making and intervention with the family.

For example, in a case which involves significant and serious physical injuries to a child that are thought to have been inflicted by a parent, and where neither parent is acknowledging responsibility for the injuries, colluding with the abuse and protecting each other, it would be useful to have a specialist assessment of each parent's individual functioning, the dynamics of the couple relationship and the implications for future parenting capacity.

Seek advice from your regional principal practitioner if you need to access a specialist assessment because it will be important to clearly determine the kind of specialist assessment required and ensure the professional selected is suitably qualified, experienced and accredited. Make sure that you provide a good referral with all the pertinent documentation and history so that the specialist is as well briefed as possible.

Practitioners need to think critically about the information received, draw together the various facts and perspectives and analyse the impacts on children's rights, safety, stability and development. It is important that your analysis takes into account the range of factors that constitute risks to children and constraints to adequate parenting capacity.

Planning your intervention

After collating the information you have gathered, you should have a comprehensive family assessment, a clear analysis of current parenting capacity and an assessment of actual or potential risks to children. Incorporating theoretical knowledge derived from trauma and attachment theories and your knowledge of child development, you will also have formed a view about the nature of the risks to children and the impacts, including whether or not cumulative harm is a factor.

In a child protection context, there are times when comprehensive assessment and analysis are superseded by the need for crisis intervention. While a crisis response is still based on an analysis of the available information and an assessment of risks and protective factors, a broader or fuller assessment is subsequently required.

Planning for a crisis response or a scheduled visit to a family is useful for family members and practitioners. Knowing what needs to be covered and having a tentative plan for how this might be undertaken can alleviate practitioner anxiety and contribute to clearer communication and more effective engagement.

The importance of the practitioner/family relationship

The first and most important building block of family intervention is to make a connection between the key worker and the family. This includes all individual family members within the family circle. Without a sound relationship, the possibilities for agreement, engagement and an effective partnership may be compromised. Recent research into family interventions suggests that retaining the same key worker over time was vital for families (Department for Education 2010). In highly complex cases with several children, it can be sensible to allocate two key practitioners. This provides some flexibility and may also enable more capacity to engage various parts of the family system.

Communicating respectfully and clearly

In order to build relationships and facilitate engagement and change, practitioners will need a range of communication skills including an ability to communicate clearly and consistently with the family and others. Frequently, practitioners communicate with individuals and family members who are in heightened emotional states or in circumstances of trauma and stress. It is important to stay calm, contain your own responses and remember that the behaviour is not a personal attack but a reflection of the person's feelings and circumstances.

Managing yourself and others

From the early stages of contact with a family, throughout your involvement, it is vital that you continue to know and manage your own feelings and values, and be able to recognise and manage the emotions of others. This will be helped by supervision and reflective practice processes in your workplace.

Role clarity

In planning your intervention with a family, it is necessary to understand your role and its limits, to know about organisational procedures and relevant legal frameworks and to have thorough knowledge of local resources and supports that may be of use to the family.

Planning with the family

Goals for the child, young person, parent and family need to be formulated *with* the family. Involving the family in setting goals is empowering and can also help and enable family members to have ownership of the agreed goals. Plans for intervention must prioritise the child's needs but are also set with the family. Goals help families to solve problems and work towards their longer-term vision for themselves and their children.

Planning informed by professionals

Planning must also be informed by professionals and services involved with the family. It is necessary to form a multi-agency team to participate in setting goals and plans with the family.

Specifying goals

Goals must be tied to identified concerns, be specific, achievable and prioritised. Clear timelines and consequences must be associated with each goal and it must be clear which person is responsible for each goal.

Make sure the goals are SMART: Specific, Measurable, Achievable, Related to the concerns and Timely.

(See the goal planning tool in the analysis and planning section of the Best interests case practice model summary guide, for more information)

Identifying resources and supports

Identify the key resources, supports and services that will be necessary to help the family address the stipulated goals. There may also be non-professional support people in the extended family or friendship network who can assist parents and family to access the identified services.

Documenting the plan

It is important to document agreed goals, plans, roles and responsibilities and timelines for review. Regular review enables an evaluation of progress and/or constraints to achieving stipulated goals.

Planning mechanisms for child protection practitioners

For child protection practitioners, effectiveness in working in partnership with families and with other professionals and services will be aided by formal departmental planning mechanisms. As part of your intervention you will need to undertake one or more of the following plans:

- a case plan
- a cultural support plan
- a stability plan.

Thoughtful consideration of what planning mechanisms are required will enable you to coordinate plans where the goals are clear and the family has been included in their development.

Where parenting is inadequate, poses risks to children or compromises their safety and development, the role of child and family services and child protection practitioners is to 'provide the widest possible assistance' (Child Youth and Families Act, s.10) to support parents to parent adequately.

Action

Supporting families with multiple and complex needs

Parents across different cultures and diverse communities share common goals for their babies when they are born. Most parents have hopes and aspirations that their child, through infancy, childhood and adolescence will be safe, physically healthy, emotionally stable, reach their potential through education, learn to behave in socially acceptable ways and become a happy and productive member of society.

Most parents are able to achieve their parental goals with assistance and guidance from a network of family, friends and community supports. Most parents in Australia will have access to universal services such as health and education to help them and some will seek additional support from statutory or voluntary services. Vulnerable families are those who have a limited network of family and community support and find it difficult to access additional services. Particularly vulnerable families are those that have been impacted by social disadvantage and have family members who may have physical or mental health problems, disability, substance abuse or have experienced family violence. Single parent families, parents who have experienced abuse and neglect and poor parenting themselves and those who have not had models of effective parenting may struggle to parent their children and raise them in the way they intended. They may also feel embarrassed to seek help or be fearful due to previous experiences with the 'welfare'.

Families experiencing complex and multiple difficulties often require significant support because they are frequently at risk of statutory intervention and because they often fall below existing service thresholds, have difficulties engaging with services, or require an intensive family intervention. Frequently, these families do not get the most effective support (Department for Children, Schools and Families 2007).

Prioritising your interventions

Most practitioners will be familiar with Maslow's hierarchy of needs (McAdams 2006) which proposes that human beings have a natural drive to fulfill their potential but this cannot be achieved unless other, more basic needs are first fulfilled. In order to be able to support people, we need to address their needs in a systematic way that concentrates on meeting basic needs before progressing to the next level. For example, it is not much use focusing on building parenting skills for a single mother struggling to feed and house her children.

The following case example illustrates the multiple and interconnected nature of the family's difficulties and the need to prioritise and stage interventions. The timing of the interventions will also be critical so as not to overwhelm the family.

Case example

Jane is a single mother with six children, ranging from one to ten years. She lives in a three-bedroom house and the two youngest children share a bedroom with her. Jane is on a pension and struggles financially. She does not have a washing machine that works and does not own a car. Her two oldest sons were sexually abused by a neighbour and as a result, both are exhibiting angry and sexualised behaviours towards their siblings and are also acting out at school. Jane needs to ensure that the children are supervised all the time to ensure adequate safety; she needs to make sure that she attends weekly counselling appointments with each of her sons and regular meetings at the school to discuss the boys' behaviour. She has no transport and no childcare. Jane herself grew up in a single parent family. Her mother had mental health difficulties that affected her parenting capacity and the home environment was characterised by neglect. Jane and her younger sister were sexually abused by their grandfather throughout their childhood. She has no contact with her family and has few friends and social supports.

In addition to dealing with normal challenges of parenting, parents with multiple and complex needs are facing the (often long-term) experience and consequences of disadvantage and may also be struggling to come to terms with their own experiences of trauma and victimisation. Your respect and understanding is vital to helping families such as Jane's. Gaining their trust that you will be reliable and follow through on what you promise, can make all the difference to their engagement in the services and helping the children.

An effective intervention is planned and purposeful, and staged to meet the family's needs and capacities over time. Interventions are prioritised according to the level of need.

Identifying resources needed to meet goals

Within the family intervention process, the multi-agency team makes decisions about what kind of support the family needs and wants and who might provide it, in consultation with the family and key worker. It is useful to consider informal and formal networks of support.

What is support?

The focus for practitioners is to support families. However, the term support is very general and can be wide-ranging and vague.

'It's easy to respond to a problem by saying we need more support without being at all clear on what we mean by that or what we want to achieve' (Quinton et al 2004).

Support is complex to access, tailor correctly and deliver. This is partly because it is difficult to balance the family's need for assistance with the problem of intrusion, and partly because different services are bound by service delivery contexts, boundaries and roles. Despite these complexities, it is critical that practitioners are clear about what type of support, what this might involve for key practitioners, and which agency is best placed to provide this support.

What kind of support?

In thinking about the type of support a family needs to meet its goals, it can be useful to apply the following grid.

| Type of support | What this might involve for key workers | Internal or external family or community resources that could be utilised | Which agency is best placed to provide this support? When should this occur? |
|------------------------|---|--|---|
| Practical support | Assistance with basic tasks to address primary needs | | |
| Emotional | Assistance with managing feelings | | |
| Social networking | Assistance to build family, social and community links | | |
| Professional | Targeted support from trained specialists | | |
| Knowledge, information | Assistance with problem solving | | |
| Referral | Targeted referral to specialist support | | |
| Financial | Assistance with financial matters | | |
| Advocacy | Negotiating on behalf of the family, representing its views | | |
| Training/learning | Learning and training opportunities | | |
| Challenge | Keeping family in the process of addressing goals and achieving changes | | |

Children's Workforce Development Council 2010

This grid provides a guide to the type of support required and who might provide the support, but decisions also need to be made about prioritising needs and tasks and the timing of these. Sometimes more thinking needs to go into refining referrals for specialised therapeutic support.

As such these questions need to be considered:

- Who is best placed to deliver the kind of support needed – family, extended family, community or services?

- Which referrals need to be made immediately, which can wait? Which services are needed to address immediate, short, medium or long-term goals? For example, any bruising or physical injuries require an urgent response and specialist forensic medical attention, particularly if there are concerns about the explanations for the injuries or their pattern and history.
- What specific referrals need to be made for the particular issues presented for this parent and for this child? Be careful not to compartmentalise all the issues, overload the family with appointments and have too many professionals in their lives with too little coordination. Have you considered how the parents can access the appointments? Plan the practical details of the transport and childcare needs.
- If there are several problems requiring a therapeutic intervention (for example, a mother's substance abuse and her underlying history of sexual abuse trauma and children's behavioural problems), how are referrals tailored and services effectively delivered? Always seek the input of family members regarding what they think are the most urgent priorities and then try to address the other important priorities. You may have to show leadership and take a position that some aspects are not negotiable – such as the child attending school or the baby going to the doctor – even though that may not be a priority for the parent. You will need to have concurrent planning and multi-task in many circumstances, as a multi-pronged and intense process is often needed to address situations of chronically overwhelmed families.
- Will the referred provider have sufficient focus on the child's safety and wellbeing? How can this be optimised? Be clear with adult-focused services that there are parenting issues and that they need to hold the safety of the children in mind and work collaboratively with you.
- Can members of the extended family or local community be called on to help with interventions and build ongoing support around the family?

It is helpful to have one practitioner to maintain general oversight of the interventions and coordinate information and action across the services in which the parents and children become involved. This person can also ensure that the child's safety and wellbeing are closely monitored and respond accordingly.

Ensuring service engagement

It is important to plan your intervention and prioritise interventions according to the needs and capacities of the family. Referring a family to a different service or professional for each problem or trying to address all problems simultaneously will be overwhelming for the family and ineffective. An effective intervention plan is purposeful and staged to meet the family's needs and capacities over time.

Moreover, effective intervention involves more than identifying and referring a family for services. It is not enough to refer a family to a service and expect or assume that the family will have the capacity to engage with that program. It is essential for practitioners to ascertain whether a parent or family has made a 'meaningful' engagement with a service provider or agency, rather than non-engagement or 'superficial engagement'. It is not uncommon for practitioners to assume that service engagement has taken place on the basis of referral only, or to assume that the parent or family is attending, or to assume that they are meaningfully engaged in addressing concerns when it may be that they are engaged at the level of compliance only.

Service engagement is not constituted by a referral to a service. Nor is it a compliance task or a superficial activity undertaken by a family in response to other's concerns. It involves a commitment by the family to addressing concerns and making changes with the assistance and support of the service provider, and a commitment by the key worker to ensure that service engagement is meaningful and working towards meeting the family's goals and improving the lives of the children.

Building a partnership with families

In the action phase, just as in the planning phase it is critical that you plan your intervention *with*, rather than *for*, families. The goals of the intervention need to be developed with the family and extended family and it is critical that the goals are concrete, behavioural and measurable. The parents need to know when they have been successful and the practitioners need to engage them in meaningful ways that build confidence. Similarly, if current concerns continue, or new concerns emerge in the process of the family intervention, these need to be directly and respectfully raised with parents. A focus on the safety and wellbeing of the child needs to always be kept in mind. 'Practitioners must find the balance between providing support and validation whilst being able to directly challenge neglectful and other aspects of poor parenting' (Frederico, Jackson & Jones 2006).

The reasons for child protection or family services involvement must be clearly understood by the family. Clear goals and outcomes need to be established in partnership with the family in relation to what needs to change for the child and how parents will work towards these goals.

Working in partnership with other services

It is critical that services involved with children and their families communicate and collaborate with each other, sharing appropriate and relevant information regularly. You may need to consult with maternal and child health nurses, teachers, Aboriginal Child Specialist and Support Services, domestic violence, drug and alcohol, mental health, housing and disability services.

Regular case conferences are essential for professionals connected with the family – and family members themselves – to work together to explore current concerns, past patterns and practical solutions.

Regular professionals' meetings are important for ongoing cases, and care teams, which can include professionals, family members and others involved in caring for the child, are also important mechanisms for collaborative and effective work.

Partnerships and well-functioning care teams are critical in protecting and caring for children.

Barriers to change

The complexity of a family situation and the cognitive, physical and emotional effects of multiple and complex problems such as mental illness and family violence can limit the capacity of a parent to engage easily or fully in an intervention.

For example, some acquired brain injuries, intellectual disability, mental health problems or the side effects of some medications can lead to confusion or extreme fatigue, making it difficult for the parent to understand what is required of them or to be physically capable of accessing a service outside the home. Some aspects of the intervention may need to be implemented quickly to protect the child, so when putting a plan into action practitioners need to ensure that the process is not overwhelming for the parent or child. Practitioners need to consider potential barriers to change.

Be aware of power differentials in your relationships with families. The greater the differences in power, the more anxious and fearful parents are likely to become (Perry 2010). Reflection becomes critical when it unmasks how power ‘underpins, frames and distorts interactions’ (Dolan Pinkerton & Canavan 2006).

The assessment and planning phase will have highlighted the kinds of non-professional support, programs and services likely to benefit the parent and child and suggested a logical and manageable sequence by which participation or access can be initiated.

Protection and assistance: families with multiple and complex needs

The CYFA 2005 best interests principles state that practitioners must give the widest possible protection and assistance to the parent and child as the fundamental unit of society, and strengthen, preserve and promote positive relationships between family members.

Given that families experiencing multiple and complex problems are typically situated within a broader context of poverty and disadvantage, it will be necessary to consider several key domains of support to ensure sufficient assistance to meet a range of needs.

Practice tips

The following practice tips highlight general interventions that can be important for families with multiple and complex needs:

- Do not underestimate the value of addressing immediate material and/or practical needs for families under stress.
- Attend to sources of non-professional support that may be helpful to the family. Engage and involve trusted community members who know the family well and are prepared to support and/or advocate for the family.
- Help family members to make sense of their current difficulties by assisting them to create and understand the context surrounding the family issues.
- Help family members connect their current circumstances with past experiences. This helps to reduce stigma, pathologising and individual blame and is a useful vehicle for hope and change.

- Provide education on trauma and its impacts, responding to indicators of trauma in adults. Parents can benefit from assistance to recognise and manage patterns, responses and behaviours associated with their own trauma.
- Provide opportunities for parents for teaching and modelling of new parenting skills. Often intensive family intervention targeted at parenting can be very effective.
- Provide access to individual therapy for parents to address their individual issues and concerns. This can be critical to their parenting capacity and their healing from adverse experiences.
- Provide access to therapeutic services for children and adolescents to address the impacts of significant adversity, create emotional and psychological safety, repair attachment disturbance and promote healing and recovery.
- Think beyond safety to the critical importance of recovery. Family relationships damaged by abuse, neglect, trauma and other kinds of disadvantage will typically require specialised therapeutic interventions to promote healing. Individual therapy is important for adults and children, but recovery and healing is closely related to family relationships. Attention needs to be paid to parent/child and family relationships as important sources of healing. Conjoint, parent/child and/or family therapy can be important therapeutic interventions.

As discussed above, it will be important to consider the families' need for:

- material assistance
- assessment and therapeutic treatment services
- effective parenting interventions
- targeted and specialist support
- social and community resources
- advocacy
- longer-term intervention.

It will also be important to recognise the need for intensive family and parenting interventions for families experiencing multiple and complex needs. This has been well documented and makes sense, given that many of these families have more than five significant disadvantages (Social Exclusion Taskforce 2007).

Intensive family intervention has been shown to produce successful outcomes for families presenting with multiple and complex problems. These outcomes are sustained and often improve in the months after the end of intensive family intervention (Social Exclusion Taskforce 2007).

The key worker in these intensive interventions can build trust and rapport with the family, model pro-social behaviours, positive parenting, reliability and hope, and has the capacity to address the range of supports needed while remaining involved over a longer term.

The role of child and family services and child protection is to educate and support parents who are struggling to parent adequately to meet their children's needs. Think about what interventions and assistance you might provide that will give parents opportunities to learn good parenting skills.

Preparing matters for court

Child Protection must present evidence to the court that demonstrates the effects of the parent's problems on the child. The analysis must present the current impact of the key problems (such as substance use, learning difficulty, domestic or family violence, mental health issues) on parenting capacity, the harm this has caused or is likely to cause, the child, and the likely outcomes for the child should circumstances remain unchanged. The court will want to know what assistance has been provided to the family and the outcomes of previous interventions.

Parenting capacity and children in care

A unique challenge for child protection practitioners is to ensure that the criteria used to justify removing a child from their family – where parenting capacity is affected to the point where the child is harmed – and those that parents must meet to be reunited with their child are equivalent. It is important that parents can ensure the safety, security and stability of their children and demonstrate that their parenting is adequate enough to promote children's development and wellbeing. From the moment a child is removed from home, we need to be focusing on what needs to change so that the child can return home if this is in his or her best interests. From the outset, the goals and supports for the parents need to be clearly understood.

Reviewing outcomes

Working with families with multiple and complex needs and problems requires ongoing review and reflection of information, intervention and action. As the intervention unfolds, new information may come to light or new issues emerge that alter the circumstances for the family and these need to be examined, assessed and addressed. The effectiveness of what you do with and for clients needs to be constantly monitored and reviewed.

Since all families are different, good practice would generally involve trying several strategies or interventions before developing an approach that works. However, where a family is facing multiple and complex problems, implementing interventions that have not been thought through thoroughly may exacerbate problems by depleting already limited parental resources or discouraging further participation in the process, and putting the child at further risk. The effects of actions that deal with the immediate effect of parental problems need to be reviewed regularly.

For families experiencing multiple and complex problems, it can be difficult to achieve positive and sustained changes. When problems seem intractable, practitioners themselves may feel stuck, overwhelmed or unsure of the most appropriate interventions. Practitioners need to access appropriate supervision throughout the process of information gathering, analysis and planning, action and review.

Assessing and monitoring progress

Assessing and monitoring progress should take place informally on an ongoing basis, as well as formally as part of regular review meetings where the family progress is reviewed and monitored in accordance with the action/support plans. Regular review is a critical feature of effective support and intervention.

Review is important to:

- allow families to ascertain their progress
- refine goals
- address concerns
- reward achievements
- create new goals
- ensure that services and supports are being used to good effect.

Critical questions to be asked at the point of review include:

- Has the goal/s been met?
- What is the evidence that the goal/s has been met?
- What are the outcomes of the goal/s being met from the family's viewpoint?
- What are the outcomes of the goal/s being met from the worker/agency perspective?
- What were the actions/steps/processes that allowed the goal/s to be met?
- What strengths/resources of the family were involved in meeting the goal/s?
- How does the family rate its progress?

- What has changed or is different for the family?
- Has the change been sustained?
- What has constrained goal/s being met, or change achieved?
- Has the child and family received the necessary support?
- Which services and approaches have been most effective?
- Which strategies are not working well or at all? What needs to change to make them more effective?
- Is a different type of support or service required?
- Is additional support required to promote change/achieve goals?
- Have the child's needs for safety, stability and wellbeing been addressed? Is this child safe and developing well?
- What else needs to occur to ensure the child's best interests are met and effectively promoted?

Parental willingness and capacity to change

As difficult as it can be to witness the struggles of some parents attempting to change their situations, ultimately if a parent will not or cannot change, or it will him or her take too long, the needs of the most vulnerable family members, the children, have to be prioritised.

The short and long-term effects of risks to children and deficits in parenting matter, whether there is intent to harm or not. Remember that the desire to change dangerous and/or neglectful behaviours does not equal capacity to change. Sustaining change is hard work and requires commitment and consistent evidence of changed behaviours.

While allowing parents the space to actively work on improving their situation, practitioners need to continually ask:

- Have parents been provided 'the widest possible assistance'?
- What is their willingness to change?
- What is their capacity for change?
- Will parental change take place in a timely enough way given the child's age and developmental needs?
- Can the child wait? What would be the impacts of waiting for parental change? What would this mean for the child practically, developmentally, emotionally, educationally etc.
- Do indicators of improvement constitute sufficient change for the child?
- Do I as the practitioner recognise that the parent does not have the capacity for change but am unable to articulate this reality?

When working with parents with multiple and complex problems, our attention is often focused on the parents, their worries and struggles and the efforts that they are making to change. Cousins (2005) writes: "Sometimes, in our own hope to see things improve, we can focus on improvements that are not actually about change for the child" (page 5). Similarly, practitioners can be overly optimistic about changes and assume short-term shifts in the present are equal

to sustained changes in future. For serious and enduring parenting problems that have led to considerable concerns for children's safety and wellbeing, it is important to have evidence of sustained and not episodic change (Sutherland and Miller 2012). You need to ask:

- What's changed for the child? How do we know? Is the physical, emotional and social environment now safer for the child? Are they making progress in terms of cognitive, physical, emotional and social development?
- What treatment or support has the child received to help them process the overwhelming events? Has this helped? How do you know?
- Is the child safe, stable, more able to play, concentrate, relate, participate and belong?

Ultimately the effectiveness of your intervention is measured in terms of what has changed for the child.

Reviewing your practice

Just as it is necessary to review the progress and outcomes for families, it is important to review the work you have done with a family and reflect on your practice. Supervision and reflective practice sessions are opportunities for you to review your work in an ongoing way. Supervision and reflective practice are especially important for practitioners given the complexity of issues likely to be present for families with multiple, inter-related and/or chronic problems.

For example, it is important that your assessment of a mother who has just disclosed ongoing violence at the hands of her partner is a contextual assessment, that is mindful of the shock, distress and emotional 'shutdown' that may lead to her being viewed as an irritable and insensitive mother. A gendered analysis that does not imply 'mother blame' is crucial, however it is also of primary importance that the children's needs are not lost in the crisis and marginalised by the adult distress and focus. This requires practitioners to be well supported and receiving good supervision so that the balancing and weighting of these factors leads to sound planning and action. Taking the time to discuss the layers and complications will improve the quality of your work and interventions with these families.

Supervision

Regular supervision for practitioners and for managers is essential to the provision of quality services for clients. It is in this context that practitioners can learn and develop, analyse and plan interventions in relation to the family, consider dilemmas and concerns and develop strategies to guide their work. It is also in the supervision context that a practitioner is able to reflect on the personal impacts of working with vulnerable children and families and obtain professional and organisational support. Further, supervision permits a context in which practitioners can reflect on their own values and practice to ensure that respectful and quality work with children and families is maintained.

Reflective practice

Practitioners can benefit from opportunities to reflect on their practice. Secondary consultations and reflective practice sessions provide space to think about the work, focus on particular cases, analyse the process of work with families, discuss 'stuck points' and develop strategies to guide future work. They also provide an excellent process for learning and development and peer support. Just as supervision contributes to improved skills in individual practice, reflective practice can influence the development of practice culture in an organisation, promoting quality practice and improved outcomes for children and their families.

Appendix

IMPACT TABLE 1: How does parental substance use affect parenting?

| Individual impacts | Parenting impacts | Risks to children |
|---|---|--|
| <p>There are many types of licit and illicit substances. The substances most commonly associated with concerns about parenting are: alcohol, opioids (heroin, cocaine), amphetamines (ecstasy, speed), psychoactive drugs (marijuana) and overuse of prescription drugs.</p> <p>Substance use affects the brain, impairing the senses (e.g. blurred vision, impaired hearing), perception (e.g. reaction-time, balance), motor skills (e.g. impaired coordination, shaking), speech and judgement (e.g. reason, caution, self-restraint, inhibitions). Depending on the nature of the substance, it may act on the brain as an accelerant (e.g. methamphetamine) or a depressant (e.g. alcohol). Some substances can induce violence (e.g. alcohol) or paranoia (e.g. 'ice') in some users. Substance misuse may result in extreme lethargy, tiredness, lack of consciousness or 'passing out', coma and death.</p> <p>Withdrawing from addictive drugs can also have severe effects such as increased anxiety, irritability, sleeplessness, depression, vomiting and paranoia (NSW Department of Community Services 2004).</p> | <p>Symptoms of intoxication and withdrawal may make it difficult for parents to maintain household tasks and routines such as preparing meals, ensuring the child's clothes are clean, supervising children, maintaining regular routines for school attendance and responding to their children's emotional needs (Dawe, Harnett, & Frye 2008).</p> <p>Financial difficulties may also arise as household essentials such as food, clothing and bills may be ignored in order to pay for drugs (Dawe et al 2007).</p> <p>Inconsistent parenting as a result of fluctuating mood swings may result in parents sometimes using controlling, authoritarian and punitive parenting and at other times permissive and neglectful parenting (Dawe et al 2007). Parents, when misusing substances have reported yelling more often, being inattentive, more self-focused, using reactive or authoritarian parenting, creating an atmosphere of secrecy and allowing the child to take on a parenting type role (Odyssey House Victoria 2004).</p> | <p>There is a high risk of neglect for children whose parents misuse substances. For example, poor supervision may lead to basic needs such as regular healthy meals and clean clothes not being met. Parents' focus on their own needs means they may fail to meet their child's physical and emotional needs.</p> <p>Children are at risk of physical and emotional abuse if their parent's response to intoxication or symptoms of withdrawal is violent, reactive or punitive.</p> <p>They are also at risk of sexual abuse by the parent if they have a predisposition to abuse due to loss of inhibition.</p> <p>Physical and sexual abuse may occur when children are exposed to others with similar behaviours – especially if combined with supervisory neglect.</p> <p>Exposure to drug use, drug overdose, drug dealing and other criminal activity is also possible.</p> <p>Children may develop pervasive fears: fear of fights and violence (to parent or themselves), fear of discovery of the family secret, fear of the parent being incarcerated, fear of the child being removed, fear for parental wellbeing and safety.</p> |

| Individual impacts | Parenting impacts | Risks to children |
|---|-------------------|--|
| <p>Serious long-term health effects for chronic substance use include cancer, liver failure and heart disease, which may themselves impair functioning (Commonwealth of Australia 2007, NSW Department of Community Services 2004).</p> <p>Maintaining a substance addiction may lead to involvement in drug dealing (as a buyer or supplier) or criminal behaviour such as shoplifting, burglary or prostitution as individuals attempt to finance their drug habit.</p> | | <p>Such fears may trap children into a position where they cannot discuss their parent's drug problems or ask for help – from their parents, peers, other family members, family support networks or professionals.</p> <p>Children are at risk of poor educational outcomes. Even before birth, babies in the womb experience the adverse effects of poor diet, drugs and alcohol use and violence perpetrated on their mother. Maternal stress experienced during pregnancy can cause physiological stress responses in the foetus, which affect the amount of oxygen and nutrition received by the unborn child (Klein, Gilkerson & Davis 2008). Other perinatal complications may include withdrawal symptoms and premature births (Kroll & Taylor 2003, Tunnard, 2002).</p> |

IMPACT TABLE 2: How does violence between intimate partners affect parenting?

It is vital to consider violence between intimate partners in the context of parenting because research shows that violence between intimate partners is more likely to occur between couples with children, often beginning during pregnancy. Violence between intimate partners is overwhelmingly a gendered issue with the vast majority of incidents involving a female victim and male perpetrator (Australian Bureau of Statistics 2005). Other patterns of violence do exist (Australian Bureau of Statistics 2005), but this paper adopts a perspective from within the dominant pattern of men's violence towards women.

| Individual impacts | Parenting impacts |
|--|---|
| <p>Physical assaults may result in a range of injuries (e.g. bruising, scratches, cuts, burns, bone fractures). Long-term physical assault may result in reduced mobility, long-term adverse health effects, disability, miscarriage, sexual and reproductive health problems. A Victorian study showed that domestic violence is 'responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking' (VicHealth 2004a, p8).</p> <p>A well-established association exists between the experience of intimate partner violence and mental health problems (e.g. depression, anxiety, trauma, self-harming and suicide) (Campbell 2002, Golding 1999, Krug, Dahlberg, Mercy, Zwi & Lozano 2002, VicHealth 2004a). Although not as strong, there is also an association between domestic violence and substance use (Golding 1999).</p> <p>Domestic violence includes sexual assault by an intimate partner (Heenan 2005). In a national survey of Australian women, 12 per cent reported experiencing sexual violence perpetrated by a current or former partner and 73 per cent of women who were sexually assaulted by their partner were also physically assaulted (Mouzos & Makkai 2004).</p> | <p>Mothering</p> <p>Mothers who have experienced domestic violence are frequently held responsible for 'failing to protect' their children (Holt, Buckley, & Whelan 2008). However, research shows that mothers make considerable efforts to protect their children (Mullender et al 2002). Women may choose to remain with violent partners because they believe it is too dangerous to leave. With evidence that violence frequently continues and may actually increase after separation (Holt et al 2008), such fears cannot be discounted. These findings suggest that a blaming approach with mothers is unlikely to be helpful.</p> <p>Effects of violence (e.g. pain, distress, anger, irritability, fear, reduced mobility, hospitalisation) may affect a mother's parenting capacity, as may mental health issues or substance use problems that emerge as a consequence of domestic violence. Domestic violence may result in mothers who are emotionally distant, unavailable or unable to meet their children's needs (Holt et al 2008).</p> <p>"I didn't have the same patience with the children when he was there, because I think I was frightened he was going to lose his temper" (mother cited in Mullender et al 2002).</p> |

Individual impacts

Domestic violence is also linked with homelessness and housing instability for victims fleeing violent partners. About 100,000 Australians are homeless, including 7,483 homeless families (10,608 parents and 16,182 children). Some 12 per cent of the homeless are children under 12 (most accompanied by a parent) and a further 21 per cent are aged 12 to 18 years (mainly on their own) (Australian Bureau of Statistics 2006). Data from the Supported Accommodation Assistance Program (SAAP) for 2007–08 show that the main reason females with children sought support was domestic or family violence (55 per cent) (Australian Institute of Health and Welfare 2008a).

At its most extreme, domestic violence can result in death. In Australia, about 20 to 25 per cent of homicides were perpetrated by spouses (Mulrone 2003).

Characteristics of perpetrators

Perpetrators of domestic violence have been shown to display the following characteristics towards their spouses: control, entitlement, selfishness and self-centredness, superiority, possessiveness, confusion between love and abuse (e.g. claiming they would not become violent with them if they did not love them so much), manipulative, externalisation of responsibility, denial, minimisation and victim blaming (Bancroft & Silverman 2002). Service providers are cautioned to avoid making assessments about violent men's propensity for future violence based on their stated beliefs, because men who are violent towards their partners may make strong anti-violence statements while continuing their violent behaviour (Bancroft & Silverman 2002).

Perpetrators of domestic violence may experience homelessness, housing instability, relationship breakdown, separation from children, loss of contact and disintegration of father-child relationship, criminal charges, prosecution and incarceration as a result of their violent behaviour.

Parenting impacts

In their attempts to prevent or manage men's violence and as a result of living in fear, mothers have reported prioritising their partners' needs over those of their children and denying their children normal childhood experiences (Humphreys et al 2008, Holt et al., 2008).

"I was so hooked into placating him that I emotionally neglected the kids" (cited Mullender et al 2002).

Evidence suggests that violence can damage the mother-child relationship. Belittling, undermining, insulting and hitting women in front of their children may affect children's respect for their mother's authority (Bancroft & Silverman 2002, Humphreys 2007), and her ability to exercise authority and control over her children (Holt et al 2008).

Some research suggests that the effects of domestic violence on mothering may not be permanent. A US study found that women who had experienced intimate partner violence but were no longer victims had significantly better parenting scores than women who were experiencing intimate partner violence. However, there was no significant difference between women who had experienced intimate partner violence in the past and women who had never experienced intimate partner violence (Casanueva, Martin, Runyan, Barth & Bradley 2008). On a similar theme, children who had escaped domestic violence with their mothers predominantly felt that their fathers were to blame and reported wanting to stay with and support their mothers (Mullender et al 2002).

Individual impacts

Fathering

Research is limited on the effects of domestic violence on father-child relationships and on men's capacity to father. The fathering practices of men who are violent towards their intimate partners will vary along a continuum of abusive to optimal parenting. However, it is important to highlight that a man who perpetrates domestic violence can never be a fully responsible parent, because exposing children to domestic violence is itself abusive (Bancroft & Silverman 2002).

Bancroft and Silverman (2002) identified common parenting characteristics of men who were violent towards their spouses. They suggested that men who were violent towards their spouses were more likely to:

- Have developmentally inappropriate behavioural expectations of children.
- Generally be under-involved with their children and less physically affectionate, but at times (and unpredictably) to be powerfully present in the child's life, interacting with energy and humour and spending money freely.
- Be authoritarian and rigid when involved in the disciplining of children and more likely to use physical punishment and 'smack hard'.
- Be self-centred and put their own wants above the needs of their children, or even believe that children exist to meet their fathers' needs.

"They were never allowed to talk, they were never allowed to play, they had to be quiet. My son did not talk until a year after we left the refuge, because that's what they had to do at home ... They knew what he was like, I never had to say anything"
(Mullender et al. 2002).

Parenting impacts

Children *experience* rather than passively witness domestic violence

The term 'witnessing' domestic violence implies that children are passive witnesses who see or hear the violence between the adults in their home. However, research shows that children – rather than being passive witnesses – *experience* domestic violence.

In a US study, mothers reported that 37 per cent of children were accidentally hurt during domestic violence, 26 per cent of children were intentionally hurt during domestic violence, 49 per cent of mothers were hurt protecting children, 47 per cent of perpetrators used the child as pawn to hurt mothers, 39 per cent of perpetrators hurt mothers as punishment for children's acts, and 23 per cent of perpetrators blamed mothers for perpetrator's own excessive punishment of children (Fox & Benson 2004).

Children are sometimes hurt as part of the torture and abuse of their mothers. They may be held hostage or threatened. Children may also be forced to watch or perpetrate the abuse of their mother, other siblings or pets (Radford & Hester 2006, Humphreys et al 2008).

Exposure to domestic violence is abuse

The psychological effects of witnessing verbal, physical and sexual assaults perpetrated on the mother, combined with the effects of living with a father who is frightening, inconsistent, intolerant and unable to put children's needs first, is abuse.

The toxic stress and complex trauma caused by living in a perpetual state of alert can damage the developing brain and have profound long-term psychological effects.

Individual impacts

- Behave in a manner that suggests they are jealous of their children. For example, many women report domestic violence starting during pregnancy and men being more likely to direct their assault towards the breasts and abdomen during pregnancy. Mothers and children frequently identify family events such as children's birthdays as occasions of violence.
- Undermine their children's mother (in addition to being violent towards her) by overruling her parenting decisions, ridiculing, belittling and insulting her in children's presence or to children and telling children that their mother is a bad or unsafe parent.
- Be manipulative with their children, for example creating confusion about which family members are responsible for violence and encouraging children to blame themselves or their mothers.
- Make statements and express emotions regarding their love and pride for their children and desire to be involved in their children's life, despite the reality of their under-involvement.

Children's reports of the damage or disintegration of the father-child relationship as a result of domestic violence cite betrayal of trust, loss of respect, seeing their father as a source of fear and terror, loss of love and hatred for their father (Mullender et al 2002).

"We do not see my dad now and don't want to see him. I am happy about not seeing him." (8-year old South Asian girl, cited in Mullender et al 2002).

Parenting impacts

Effects of exposure to domestic violence

Children living with domestic abuse display physical, developmental, psychological and behavioural effects, as well as the impact of trauma and developmental regression. They have been shown to have significantly poorer outcomes on 21 child psychosocial, developmental and behavioural dimensions, compared with those who do not witness abuse. Behavioural problems include acting out, violence and aggression towards others. Outcomes for child witnesses were similar to those where children were also directly physically abused (Kitzmann, Gaylord, Holt & Kenny (2003).

Risks vary at different ages and stages

Family violence has different effects on children at different ages. In utero, the mother's physical and emotional distress has a direct impact on the developing foetus (Jordan, Sketchley, Bromfield, & Miller, in press). Assault of the mother may result in miscarriage, premature birth, physical injury or disability (Cleaver, Unell & Aldgate 1999, McGee 2000). Infants and younger children are at risk of being harmed while being held in the mother's arms during an assault; older children may be harmed while intervening to defend their mother from assault (Humphreys et al 2008).

Risks of physical abuse or sexual abuse

The presence of domestic violence puts children at higher risk of experiencing physical abuse, with rates of co-occurrence ranging from 45 to 70 per cent (Holt et al 2008).

Evidence also exists that the presence of domestic violence increases the risk of child sexual abuse (Holt et al 2008). If children are sexually abused, they may also be less likely to disclose. Perpetrator manipulation, threats and intimidation; damage to mother-child relationship; and a belief that their mother cannot protect them may delay or decrease the likelihood of disclosure.

| Individual impacts | Parenting impacts |
|---------------------------|--|
| | <p>The effects of domestic violence on women can result in mothers who are emotionally distant, unavailable or unable to meet their children's needs and therefore increase the risk of children experiencing neglect.</p> |

IMPACT TABLE 3: How do parental mental health issues impact parenting?

The term ‘mental illness’ is usually used when referring to a specific diagnosable disorder such as schizophrenia, while the term ‘mental health problem’ is used to refer to problems that interfere with a person’s daily functioning but to a lesser extent than a ‘mental illness’ (Huntsman 2008).

The mental health issues included in this table are depression, bipolar disorder, schizophrenia, borderline personality disorder, post-traumatic stress disorder and antisocial personality disorder.

| Individual impacts | Parenting impacts | Risks to children |
|--|--|--|
| <p><i>Depression</i> is a mood disorder. Symptoms include depressed mood (sadness, emptiness), sleep disturbances (not being able to sleep well or sleeping too much), loss of interest, motivation and energy, difficulty concentrating, holding a conversation, paying attention or making decisions that used to be made fairly easily, and suicidal thoughts or intentions.</p> <p><i>Bipolar disorder</i> is also a mood disorder in which individuals experience episodes of mania and depression. Mania is an intense high where the person feels euphoric, may have elevated self-esteem, be talkative, have reduced need for sleep, and be easily distracted. This ‘high’ quickly fades after which intense depression is often experienced, which can be exacerbated by rash decisions made while manic (e.g. spending too much money, misuse of drugs or alcohol).</p> <p><i>Schizophrenia</i> is a psychotic disorder typically emerging in adolescence or early adulthood in response to stress. Symptoms include delusions, hallucinations, disorganised behaviour/speech, flattened or inappropriate emotions, and poor social interaction.</p> | <p>Research on the effects of mental health issues on parenting is limited and has mainly concentrated on depression (Huntsman 2008). The symptoms of a mental health issue can impact on a parent’s perception, cognition and communication (Hegarty 2005, NSW Department of Community Services 2004). Problems in parenting associated with mental health conditions have included being emotionally unavailable, withdrawn, unresponsive, overly critical, being disorganised, inconsistent, tense, less happy and active with children (Mowbray et al 2000).</p> | <p>Children of a parent with a mental illness or mental health issue face a high risk of physical neglect. Basic needs may not be met, such as having regular, healthy meals and clean clothes.</p> <p>Parents may fail to attend to children’s emotional needs, which can instill a sense of isolation and mistrust in children.</p> <p>There are risks of physical and psychological abuse by parents, if symptoms of illness contribute to the parent being violent, reactive or punitive.</p> <p>Attachment difficulties may arise for babies and infants of mothers with maternal mental health problems such as depression (Cowling 2004).</p> |

| Individual impacts | Parenting impacts | Risks to children |
|---|---|--|
| <p><i>Borderline personality disorder</i> is most commonly diagnosed in females and often when there is a childhood history of unstable relationships, sexual abuse, family violence or neglect. Major symptoms are unstable relationships, poor or negative sense of self, inconsistent moods, impulsivity and an intense fear of abandonment. Symptoms are constant, enduring, impact most – if not all – aspects of life and typically emerge during adolescence.</p> <p><i>Post-traumatic stress disorder (PTSD)</i> occurs in response to a traumatic event. Symptoms typically emerge soon after the event, but may take years to manifest. Symptoms can be enduring if untreated and include re-experiencing the trauma through nightmares, obsessive thoughts, flashbacks, avoidance (of situations, people, objects that are reminders of the traumatic event) and increased anxiety.</p> <p><i>Antisocial personality disorder</i> is sometimes referred to as psychopathy or sociopathy and is characterised by a pervasive disregard for others' rights. It is preceded by a history of conduct disorder through childhood and adolescence, marked by violations of norms relating to aggression towards people and animals, destruction of property, deceitfulness or theft, or serious violation of rules.</p> <p>Other characteristics that may be associated with this disorder include engagement in unlawful behaviour; arrogant, opinionated, superficially charming behaviour; indifference to others' wishes, rights and feelings; deceitful and manipulative behaviour; impulsive behaviour; aggressive and irritable; reckless disregard for own or others' safety; irresponsible with respect to work and money; and indifference, showing little remorse, minimising harmful consequences (American Psychiatric Association 1994).</p> | <p>Difficulty controlling emotions can cause parents to become unnecessarily angry with their children. A mental health problem may make it difficult for parents to get out of bed in the morning to take their children to school. Loss of motivation can also cause difficulties in performing basic tasks such as housework or shopping (Hegarty 2005).</p> <p>Some mental health concerns can cause a parent to become withdrawn and focused on themselves at the expense of their children.</p> <p>Mental health issues can also cause inconsistent and irrational parental behaviour, which can leave children frustrated and confused.</p> <p>The characteristics of antisocial personality disorder can lead to lack of responsible parenting in the areas of safety, hygiene, nutrition, responsive nurturing of feelings, illnesses and physical injuries, and managing money for household goods.</p> | <p>Children may become 'parentified' and assume the role of a carer for an ill parent and/or sibling. This can cause significant emotional stress and disrupt a child's general development (Huntsman 2008).</p> <p>Parental mental health issues can also increase the risk of perinatal complications due to possible side-effects of medications such as anti-depressants during pregnancy and high stress levels in mothers (Cowling 2004, Huntsman 2008).</p> <p>Children of parents with a mental illness have also been found to be at risk of developing mental health problems of their own (Cowling 2004).</p> <p>Problems in a child's cognitive development may also arise due to the parent's inconsistent and neglectful behaviour (Cleaver et al 1999).</p> |

| Individual impacts | Parenting impacts | Risks to children |
|---|-------------------|--|
| <p>Other mental health issues include anxiety, sleep or eating disorders, amnesia and dissociative disorders (American Psychiatric Association 1994).</p> | | <p>Recklessness associated with antisocial personality disorder and the tendency to minimise the harmful consequences of their actions can put a child at risk of serious or chronic illness, injury and death. In addition, the promiscuity and poor relationship choices made by adults with antisocial personality disorder may put a child at risk of abuse from others.</p> |

IMPACT TABLE 4: How do parental learning difficulties affect parenting?

There is no accepted definition of what constitutes a learning difficulty. Inconsistent terminology is a feature of the research: 'mental retardation', 'developmental disabilities', 'learning disabilities', 'intellectual disability' and 'learning difficulties' are terms used to describe a person with below average intellectual functioning.

In most Western countries, a person with an IQ less than 70 is deemed to have a learning difficulty. Because IQ tests cannot assess the way individuals adapt to their environment, further assessments are based on adaptive behaviour.

| Individual impacts | Parenting impacts | Risks to children |
|--|--|--|
| <p>People with learning difficulties may have difficulties developing and adapting skills that enable them to live in the community. These include communication, self-care, home-living, and safety-awareness skills and the capacity for self-direction (NSW Department of Community Services 2007).</p> <p>Cognitive difficulties affect a person's ability to source, understand and apply new information. Having a learning difficulty affects cognitive processes, which affects an individual's ability to learn new skills or generalise current skills to new situations. Cognitive limitations may include maintaining attention over long periods, learning and remembering information, problem-solving, communicating receptively and expressively and displaying appropriate social skills (Mildon, Matthews & Gavidia-Payne 2003).</p> | <p>Research on the effects of learning difficulties on parenting is limited. The research that has been done features several methodological limitations and inconsistencies in diagnosis and related terms. Recent research highlights that cognitive limitations vary considerably from person to person. Typical symptoms of the way learning difficulties may impact parenting should be viewed with caution because parents with learning difficulties differ greatly in their intellectual ability and adaptive behaviour.</p> <p>Common difficulties or problems parents with learning difficulties may encounter if they have few support networks include ensuring adequate childcare and a healthy and safe environment. Without sufficient support, parents with learning difficulties may find it difficult to meet their children's physical and emotional needs due to a lack of knowledge and understanding of available resources.</p> <p>Parents with learning difficulties may not know or understand how to access support and healthcare services and therefore their ability to know 'what to do' in a crisis may be limited.</p> | <p>Children face a strong risk of neglect in families headed by a parent with learning difficulties. A child's basic needs relating to health care, diet, hygiene, and safety may not be met.</p> <p>Parents with learning difficulties may find it difficult to attend to children's emotional needs, which can instill a sense of isolation and disrupt a child's development.</p> <p>Research demonstrates that children from families with a parent with learning difficulties are at risk of developmental delays, learning difficulties and behavioural problems (external and internal problems).</p> |

| Individual impacts | Parenting impacts | Risks to children |
|---|--|---|
| <p>In having limited communication skills, a person with learning difficulties may have trouble finding and maintaining employment and in making and maintaining friendships. For this reason, people with learning difficulties are more likely to experience socio-economic disadvantage and social isolation.</p> <p>Learning difficulties may also increase the likelihood of developing mental health concerns, with several studies finding associations with depression, anxiety, bipolar disorder and schizophrenia (Hudson & Chan 2002, McGaw et al 2007).</p> <p>Individuals with learning difficulties are also more likely to experience physical health problems, high stress levels and poorer self-esteem than other people.</p> | <p>Parents with learning difficulties may experience high parental stress particularly when their children get older or they have more than one child. High stress levels may be exacerbated when experiencing other stressors such low-socio-economic status, social isolation, a history of abuse and neglect and stigmatisation.</p> <p>Problems in parenting for parents who have a learning difficulty in combination with a mental health problem may include being emotionally unavailable, withdrawn, disorganised, inconsistent or unresponsive.</p> <p>Parents with learning difficulties may also find it difficult to provide responsive and reinforcing interactions with their children.</p> | <p>Children may not get the necessary stimulation in the home to help their general development, particularly if children's cognitive abilities surpass those of their parents.</p> <p>Parents with learning difficulties may also be vulnerable to perpetrators placing their children at heightened risk of physical and sexual abuse (Booth & Booth 1998, Tymchuk 1992).</p> |

IMPACT TABLE 5: How does acquired brain injury affect parenting?

The term Acquired Brain Injury refers to a brain injury occurring after birth and includes Traumatic Brain Injury (TBI) caused by trauma (car accident, concussion, fall, etc), stroke and other brain events, infections or diseases, substance misuse (Brain Injury Australia, undated; Research in Practice for Adults 2007).

| Individual impacts | Parenting impacts | Risks to children |
|---|---|--|
| <p>The effects of an ABI may depend on the type and severity of the injury, and the course of recovery.</p> <p>Specific effects of ABI include:</p> <p><i>Cognitive</i></p> <p>On clarity and speed of thinking; accessing and gaps in memories; reduced ability to concentrate, understand, solve problems and use language.</p> <p>A parent might need to re-learn basic skills and procedures and need to follow written instructions to complete tasks.</p> <p><i>Emotional and behavioural effects</i> include explosive anger, disinhibition, loss of motivation, and depression. Individuals may also exhibit lack of awareness and insight, moodiness, agitation and obsessiveness.</p> | <p>Parents may need to re-negotiate parenting roles between themselves, and seek help from extended family or other sources of support. This means non-family members may become involved in some parenting tasks such as travel to and from school, childcare and helping with homework (Life Supports, undated).</p> <p>Parents may experience relationship difficulties that affect the family environment.</p> <p>The physical effects of an ABI may affect the parent's energy levels and their capacity to participate actively in their child's life, from playing with them to engaging in their daily routines (having breakfast, preparing for school, attending school events). Parents may also have limited capacity to express affection or other emotions verbally or physically.</p> <p>The psychological impacts of an ABI may include lack of responsiveness to children's emotional needs and outbursts of anger directed at normal child behaviour.</p> | <p>Children may experience emotional problems resulting from the trauma of the event/cause of the parent's injury, and from coping with the range of direct (parent's diminished parenting capacity) and indirect (others' responses to parent's injury) effects of the parent's injury.</p> <p>Stress from adapting to the parent's injury and associated changes to routines and the household environment (e.g. installation of equipment), and responsibilities (e.g. taking on household chores, looking after younger siblings) may lead to impaired school performance.</p> <p>The parent's reduced capacity to empathise with their child's emotions or regulate their own emotions may result in neglect of the child's emotional needs.</p> <p>Cognitive impairment may lead to a lack of tolerance of some child behaviours (such as noise and untidiness).</p> <p>The re-negotiation of roles may mean that children need to take on tasks that would normally be done by a parent, so there is a risk of parentification of children.</p> |

| Individual impacts | Parenting impacts | Risks to children |
|---|-------------------|-------------------|
| <p><i>Physical effects</i> include damage to motor skills, balance and co-ordination; loss of ability to follow deliberate sequences of actions; loss of sensation (including vision, hearing, taste and smell); tiredness (fatigue); headaches; difficulty speaking and swallowing; bladder and bowel incontinence; hormonal changes and epilepsy.</p> <p><i>Further hormonal changes</i> (resulting from damage to the hypothalamus and/or pituitary gland) may result in:</p> <p>excessive tiredness, muscle weakness, decreased sex drive, inability to regulate body temperature, weight gain, low blood pressure, dry skin and headaches (adapted from Headway, undated (a), Headway, undated (b)).</p> | | |

References

- Access Economics 2004, *The cost of domestic violence to the Australian economy: Part 1 & 2*: Prepared for the Australian Government's Office of the Status of Women. Retrieved from <www.accesseconomics.com.au/publicationreports>.
- Adair, B 2005, 'Multicultural attitudes to parenting', *Inside Out, July/August*. Retrieved from <www.community.nsw.gov.au/docswr/_assets/main/documents/insideout/insideout_julyaug05.pdf>.
- Adam, K, Sheldon-Keller, A, & West, M 2000, 'Attachment organization and vulnerability to loss, separation, and abuse in disturbed adolescents', in S. Goldberg, R. Muir, & J. Kerr (Eds), *Attachment theory: Social, developmental, and clinical perspectives*. The Analytic Press, Hillsdale, NJ, pp. 309–341.
- Allen Consulting Group 2003, *Protecting children. The Child Protection Outcomes Project*. Melbourne: Victorian Department of Human Services. Retrieved from <www.allenconsult.com.au/publications/download.php?id=301&type=pdf&file=1>.
- American Psychiatric Association 1994, *Diagnostic and Statistical Manual of Mental Disorders 4th edition*. Washington DC: APA.
- Australian Bureau of Statistics 1996, *Women's Safety Australia, cat. no. 4128.0*. Retrieved from <www.abs.gov.au/ausstats/abs@.nsf/lookupMF/B62DEB3AC52A2574CA2568A900139340>.
- Australian Bureau of Statistics 2005, *Personal safety survey, cat. no. 4906.0*. Retrieved from <<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>>.
- Australian Bureau of Statistics 2006, *Australian Census Analytic Program Counting the Homeless 2006, cat. no. 2050.0*. Retrieved from <[www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/57393A13387C425DCA2574B900162DF0/\\$File/20500-2008Reissue.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/57393A13387C425DCA2574B900162DF0/$File/20500-2008Reissue.pdf)>.
- Australian Institute of Health and Welfare 2008a, *Homeless people in SAAP. SAAP National Data Collection annual report 2006–07 Australia*. AIHW, Canberra. Retrieved from <www.aihw.gov.au/publications/hou/hpissndcar06-07au/hpissndcar06-07au.pdf>.
- Australian Institute of Health and Welfare 2009, *Picture of Australia's children*. AIHW, Canberra.
- Bacon, H & Richardson, S 2001, 'Attachment theory and child abuse: An overview of the literature for practitioners', *Child Abuse Review*. 10(6), 377-397.
- Bancroft, J & Silverman, J 2002, *The batterer as parent: Addressing the impact of domestic violence on family dynamics*. Sage Publications, California.
- Beardslee, W 1998, 'Prevention and the clinical encounter', *American Journal of Orthopsychiatry*. Vol. 68, pp. 521–533.
- Beckett, C 2003, *Child protection: An introduction*. Sage Publications, London.

Berlyn, C & Bromfield, L 2010, 'Child protection and Aboriginal and Torres Strait Islander children'. *NCPC Resource Sheet*. Melbourne: Australian Institute of Family Studies. Retrieved from <www.aifs.gov.au/nch/pubs/sheets/rs10/rs10.html>.

Booth, T & Booth, W 1998, *Growing up with parents who have learning difficulties*. Routledge, London.

Bowlby, J 1988, *A secure base: Parent-child attachment and healthy human development*. Basic Books, New York

Brain Injury Australia, undated. *About acquired brain injury*. Retrieved from <www.bia.net.au/index.php?option=com_content&view=article&id=2&Itemid=3>.

Briere, J 2005, *Trauma Symptom Inventory (TSI): Professional Manual*. Psychological Assessment Resources, Florida.

Bromfield, L, Lamont, A, Parker, R, & Horsfall, B 2010, in preparation. 'Parenting, child abuse and neglect in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental illness', *NCPC Issues*, 33. Australian Institute of Family Studies, Melbourne. Retrieved from <www.aifs.gov.au/nch/pubs/issues/issues33/index.html>.

Bromfield, L, & Miller, R 2010, *Cumulative Harm: Specialist Practice Guide*. Victorian Government Department of Human Services, Melbourne. Retrieved from <<http://www.dhs.vic.gov.au/for-service-providers/children,-youth-and-families/child-protection/specialist-practice-resources-for-child-protection-workers>>.

Bromfield, LM 2005, *Chronic Child Maltreatment in an Australian Statutory Child Protection Sample*. Unpublished Phd thesis, Deakin University, Geelong.

Campbell, JC 2002, 'Health consequences of intimate partner violence', *The Lancet*. 359, 1331-1336.

Casanueva, C, Martin, S, Runyan, D, Barth, R, & Bradley, R 2008, 'Quality of maternal parenting among intimate-partner violence victims with the child welfare system', *Journal of Family Violence*. 23, 413-427.

Centre for Community Child Health 2007, Working with CALD families. Childcare and children's health, 10(1). Available to download from <www.rch.org.au/emplibrary/ecconnections/CCH_Vol10_No1Mar2007.pdf>.

Chan, C 2005, 'Alcohol issues in domestic violence', *Australian Domestic and Family Violence Clearinghouse Topic Paper*. Retrieved from <www.austdvclearinghouse.unsw.edu.au/PDF%20files/Alcohol_Issues.pdf>.

Children's Workforce Development Council 2010, *Supporting Families With Multiple and Complex Needs Training Key Notes Days 1-5*.

Cleaver, H, Nicholson, D, Tarr, S, & Cleaver, D 2007, *Child protection, domestic violence and parental substance misuse: Family experiences and effective practice*. Jessica Kingsley Publishers, London.

Cleaver, H, Unell, I, & Aldgate, J 1999, *Children's needs – parenting capacity: The impact of parental mental illness, problem alcohol and drug use and domestic violence on children's development*. Department of Health, London.

Commonwealth of Australia 2007, *The winnable war on drugs*. CanPrint Communications, Canberra.

Cosden, M 1999, *Substance abuse and learning disabilities: Theories and findings*. Paper presented at the CASA-NCLD Conference on Substance Abuse and Learning Disabilities, New York, NY, 1 February 1999.

Cowling, V 2004, *Children of parents with mental illness: personal and clinical perspectives*. (Vol. 1). ACER Press, Melbourne.

Cousins, C 2005, 'But the parent is trying ...' *Child Abuse Prevention Newsletter*. 13(1), 3-6.

Craig, EA 2004, 'Parenting programs for women with mental illness who have young children: a review', *Australian and New Zealand Journal of Psychiatry*. 38:923-928.

Dawe, S, Frye, S, Best, D, Lynch, M, Atkinson, J, Evans, C et al 2007, *Drug use in the family: Impacts and implications for children*: Australian National Council on Drugs. Retrieved from <www.ancd.org.au/publications/pdf/rp13_drug_use_in_family.pdf>.

Dawe, S, Harnett, P, & Frye, S 2008, 'Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do', *Child Abuse Prevention Issues*, 29. Retrieved from <www.aifs.gov.au/nch/pubs/issues/issues29/issues29.html>.

Delfabbro, P, McCormick, J, Kettler, L & Fernandez, E 2011, *Reunifications Patterns in Victoria: An analysis of social and demographic correlates*. Report prepared for the Department of Human Services, Victoria, University of Adelaide.

Department for Children, Schools and Families 2007, *The children's plan: building brighter futures*. Retrieved from <https://www.education.gov.uk/publications/eOrderingDownload/The_Childrens_Plan.pdf>.

Department for Education 2010, *Monitoring and evaluation of family interventions (information on families supported to March 2010)*. Retrieved from <www.education.gov.uk/publications/eOrderingDownload/DFE-RR044.pdf>.

Department of Health, Department for Education and Employment, and Home Office 2000, *Framework for the Assessment of Children in Need and Their Families*. Retrieved from <<http://www.dh.gov.uk/assetRoot/04/01/44/30/04014430.pdf>>.

Department of Human Services, *Child Protection Manual*. <www.dhs.vic.gov.au>.

Dolan, P, Pinkerton, J and Canavan, J 2006, *Family Support As Reflective Practice*. Jessica Kingsley Publishers, London.

Duncan, S and Reder, P 2000, 'Children's Experience of Major Psychiatric Disorder in their Parent. An Overview', in P. Reder, M. McClure and A. Jolley (Eds), *Family Matters: Interfaces between Child and Adult Mental Health*. Routledge, London.

Fantuzzo, J, Boruch, R, Beriama, A, Atkins, M, & Marcus, S 1997, 'Domestic violence and children: Prevalence and Risk in five major U.S. cities', *Journal of the American Academy of Child and Adolescent Psychiatry*. Vol. 36, no. 1, pp. 116-122.

Fenelon N, 2011, *Quality of Care – Working with Aboriginal People*. (Presentation) Aboriginal Children and Families Unit Department of Human Services.

Forum of Australian Services for Survivors of Torture and Trauma (undated). Retrieved from <www.fasstt.org.au/torture/index.php>.

Fox, G & Benson, M 2004, 'Violent men, bad dads? Fathering profiles of men involved in intimate partner violence', in R. Day & M. Lamb (Eds), *Conceptualizing and measuring father involvement*. pp. 359-384. Lawrence Erlbaum Associates Publishers, Mahwah, New Jersey.

Frederick, J & Goddard, C 2007, 'Exploring the relationship between poverty and childhood adversity and abuse from the perspective of adulthood', *Child Abuse Review*. 16, 323-341.

Frederico, M, Jackson, A, & Jones, S 2006, *Child death group analysis: Effective responses to chronic neglect*. Office of the Child Safety Commissioner, Victorian Child Death Review Committee, Melbourne.

Golding, JM 1999, 'Intimate partner violence as a risk factor for mental disorders: A meta-analysis', *Journal of Family Violence*. 14(2), 99-132.

Gorin, S 2004, *Understanding what children say: Children's experiences of domestic violence, parental substance misuse and parental health problems*. National Children's Bureau, London.

Headway (undated). *Effects of brain injury*. Retrieved from <www.headway.org.uk/Effects-of-brain-injury.aspx>.

Headway (undated). *Family reaction to a brain injury*. Retrieved from <www.headway.org.uk/Family-reaction-to-a-brain-injury.aspx>.

Healthy Start (undated). *Practitioner Resources*. Retrieved from <www.healthystart.net.au/developing.php?p=practitioner_resources&r=practice_points>.

Heenan, M 2005, 'International Violence Against Women Survey: Findings from the Australian component', *Aware: Australian Centre for the Study of Sexual Assault Newsletter*. No.6, April 2005. Retrieved from <www.aifs.gov.au/acssa/pubs/newsletter/n6.html>.

Hegarty, M 2004, *Mind the gap. The National Illicit Drug Strategy (NIDS) project to improve support for children from families where there are mental illness and substance abuse issues. Literature Review*. The Mental Health Co-ordinating Council & Department of Community Services, Sydney. Retrieved from <http://docs.google.com/gview?a=v&q=cache:FK6waSQY-_UJ:www.qnada.org.au/index.php%3Foption%3Dcom_docman%26task%3Ddoc_download%26gid%3D16%26Itemid%3D32+mind+the+gap+-+hegarty&hl=en&gl=au>.

Hegarty, M 2005, 'Supporting children affected by parental dual diagnosis – Mental illness and substance use – a collaborative mental health promotion, prevention and early intervention initiative', *Auseinetter*, 25(3). Retrieved from <www.auseinet.com/resources/auseinet/netter25/auseinetter_25.pdf>.

Herman, J 1997, *Trauma and recovery: From domestic abuse to political terror*. Pandora, London.

Herman, J 1992, *Trauma and recovery*. Basic books, New York.

Higgins, J & Butler, N 2007, 'Assessing, training and recruiting Indigenous carers. (Booklet 2)', *Promising Practices in Out-of-Home Care for Aboriginal and Torres Strait Islander Carers, Children and Young People*. Australian Institute of Family Studies, Melbourne. Retrieved from <www.aifs.gov.au/nch/pubs/reports/promisingpractices/booklets/booklet2.pdf>.

Holt, S, Buckley, H & Whelan, S 2008, 'The impact of exposure to domestic violence on children and young people: A review of the literature', *Child Abuse and Neglect*. 32, 797-810.

Hopson, B and Adams, J 1976, 'Towards an Understanding: defining some boundaries of transition dynamics', in J. Adams, J. Hayes and B. Hopson (Eds), *Transition: understanding and managing personal change*. Martin Robertson, London.

Hudson, C & Chan, J 2002, 'Individuals with intellectual disability and mental illness: A literature review', *Australian Journal of Social Issues*. 37(1), 31-49.

Human Rights and Equal Opportunity Commission 1997, *Bringing Them Home: The 'stolen children' report*. HREOC, Sydney.

Humphreys, C 2007, 'Talking to my Mum: Strengthening relationships between mothers and children in the aftermath of family violence', *Developing Practice*. 19, 12-15.

Humphreys, C, Houghton, C & Ellis, J 2008, *Literature Review: Better outcomes for children and young people experiencing domestic abuse – directions for good practice*. Retrieved from <www.scotland.gov.uk/Publications/2008/08/04112614/0>.

Humphreys, C & Thiara, RK 2010, 'Readiness to change: mother-child relationship and domestic violence intervention', *British Journal of Social Work*. Advance Access published April 8, 2010.

- Huntsman, L 2008, '*Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families. Literature review*'. NSW Department of Community Services, Ashfield. Retrieved from <www.community.nsw.gov.au/docswr/_assets/main/documents/research_parentalmentalhealth.pdf>.
- Jordan, B, Sketchley, R, Bromfield, L & Miller, R 2010, in press. *Specialist Practice Guide: Infants at risk of abuse and neglect*. Victorian Government Department of Human Services, Melbourne.
- Kitzmann, K, Gaylord, N, Holt, A & Kenny, E 2003, 'Child witnesses to domestic violence: A meta-analytic review', *Journal of Consulting & Clinical Psychology*. 71(2), 339-352.
- Klein, R, Gilkerson, L, & Davis, E 2008, *Prenatal development*. Zero to Three, Washington, DC. Retrieved from <www.zerotothree.org/site/DocServer/EarlyBrain_Unit2.pdf?docID=4461>.
- Klostermann, K & Fals-Stewart, W 2006, 'Intimate partner violence and alcohol use: Exploring the role of drinking in partner violence and its implications for intervention', *Aggression and Violent Behavior*. 11, 587-597.
- Kroll, B & Taylor, A 2003, *Parental substance misuse and child welfare*. Jessica Kingsley Publishers, London.
- Krug, EG, Dahlberg, LL, Mercy, JA, Zwi, AB, & Lozano, R (Eds.) 2002, *World report on violence and health*. World Health Organisation, Geneva.
- Lamont, A & Bromfield, L 2010, 'Parents with intellectual disability and child protection: key issues', *NCPC Issues*, 31. Australian Institute of Family Studies, Melbourne.
- Lewis, V & Creighton, SJ 1999, 'Parental Mental Health as a Child Protection Issue: Data from the NSPCC National Child Protection Helpline', *Child Abuse Review*. Vol. 8: 152-163.
- Life Supports (undated). *Adults with Acquired Brain Injury (ABI) Parenting Children Advice for Parents with ABI, their Partners and Carers*. Retrieved from <www.lifesupports.com.au/abi_info_sheets/Adults_with_an_Acquired_Brain_Injury_Parenting_Children.pdf>.
- Lipsky, S, & Caetano, R 2008, 'Is intimate partner violence associated with the use of alcohol treatment services? Results from the National Survey on Drug Use and Health', *Journal of Studies on Alcohol and Drugs*. January, 30-38.
- Loman, L 2006, *Families frequently encountered by child protection services: A report on chronic child abuse and neglect*. Institute of Applied Research, St Louis, MO.
- McAdams, DP 2006, *The person. A new introduction to personality psychology*. 4th edition. John Wiley & Sons, New Jersey.
- McArthur, M, Thomson, L, Winkworth, G, & Butler, K 2009, *Getting what we need: Families' experiences of services*. Department of Families, Housing, Community Services and Indigenous Affairs, Canberra.

McDermott, D 2008, *The What, Why and How of Koori Well-Being: Understanding and working successfully with Indigenous mental distress (DVD)*. Melbourne Health.

McGaw, S, Shaw, T, & Beckley, K 2007, 'Prevalence of psychopathology across a service population of parents with intellectual disabilities and their children', *Journal of Policy and Practice in Intellectual Disabilities*. 4(1), 11-22.

McGee, C 2000, *Childhood experiences of domestic violence*. Jessica Kingsley Publishers, London.

Mildon, R, Matthews, J, & Gavidia-Payne, S 2003, *Understanding and supporting parents with learning difficulties*. Victorian Parenting Centre, Melbourne.

Mirrlees-Black, C 1999, *Domestic Violence: Findings from a new British Crime Survey self-completion questionnaire*. British Crime Survey. Retrieved from <rds.homeoffice.gov.uk/rds/pdfs/hors191.pdf>.

Mouzos, J, & Makkai, T 2004, *Women's experiences of male violence. Findings from the Australian component of the International Violence Against Women Survey*. Australian Institute of Criminology, Canberra. Retrieved from <www.aic.gov.au/documents/5/8/D/{58D8592E-CEF7-4005-AB11-B7A8B4842399}RPP56.pdf>.

Mowbray, C, Schwartz, S, Bybee, D, Spang, J, Rueda-Riedle, A, & Oyserman, D 2000, 'Mothers with a mental illness: Stressors and resources for parenting and living', *Families in Society*. 81(2), 118-129.

Muldaly, N & Goddard, C 2006, *The Truth is Longer than a Lie*. Jessica Kingsley Publishers, London.

Mullender, A, Hague, G, Imam, U, Kelly, L, Malos, E, & Regan, L 2002, *Children's perspectives on domestic violence*. Sage Publications, London.

Mulroney, J 2003, Australian Statistics on Domestic Violence. *Australian Domestic and Family Violence Clearinghouse Topic Paper No. 3*. Retrieved from <www.austdvclearinghouse.unsw.edu.au/PDF%20files/Statistics_final.pdf>.

Munford, R, Sanders, J, Tisdall, M, Henare, A, Livingston, K, & Spoonley, P 1998, *Working successfully with families: Stage 2*. Barnardos NZ, Wellington.

Munro, E 2005, 'Improving practice: Child protection as a systems problem', *Children & Youth Services Review*. 27, 375-391.

Munro, E 2005, 'What Tools do we Need to Improve Identification of Child Abuse?' *Child Abuse Review*. Vol. 14; 374-388.

National Centre on Addiction and Substance Abuse 2000, *Substance abuse and learning disabilities: Peas in a pod or apples and oranges?* Columbia University National Centre on Addiction and Substance Abuse.

Neckoway, R, Brownlee, K, & Castellan, B, 'Is attachment theory consistent with Aboriginal parenting realities?' *First Peoples Child & Family Review: A Journal of Innovation and Best Practices in Aboriginal Child Welfare Administration, Research, Policy and Practice*, 65.

NSW Department of Community Services 2004, *Dual diagnosis support kit: Working with families affected by both mental illness and substance misuse*. NSW Department of Community Services, Ashfield.

NSW Department of Community Services 2006, 'Effective parenting capacity assessment: key issues', *Research to Practice Notes*. May 2006. NSW Department of Community Services, Ashfield.

NSW Department of Community Services 2007, *Parental intellectual disability/Learning difficulties vulnerability* (Brighter Futures Practice Resource). Retrieved from <www.community.nsw.gov.au/DOCSWR/_assets/main/documents/BRIGHTERFUTURES_DISABILITY.PDF>.

Oates, J 2010, (Ed.) Supporting parenting. *Early Childhood in Focus Series 5*. The Open University.

Odyssey House Victoria 2004, *The Nobody's Clients Project. Identifying and addressing the needs of children with substance dependent parents*. Odyssey Institute of Studies, Odyssey House Victoria, Melbourne. Retrieved from <www.odyssey.org.au/institute/projects/summary.pdf>.

Parker, R 2009, 'Helping families with complex needs: Integration of the Strength to Strength and Resources for Adolescents and Parents programs', *Family Relationships Quarterly*, No. 14. Retrieved from <www.aifs.gov.au/afrc/pubs/newsletter/n14pdf/n14f.pdf>.

Powell, MB 2000, 'Pride: The Essential Elements of a Forensic Interview with an Aboriginal Person', *Australian Psychologist*. 35: 186-192.

Quinton, D 2004, *Supporting parents. Messages from research*. Jessica Kingsley Publishers, London.

Radford, L & Hester, M 2006, *Mothering through domestic violence*. Jessica Kingsley Publishers, London.

Rankin, J and Regan, S 2004, *Meeting complex needs: the future of social care*. Turning Point, London.

Reid, G, Sigurdson, E, Christianson-Wood, J & Wright, C 1995, *Basic Issues Concerning the Assessment of Risk in Child Welfare Work*. Faculty of Social Work and Faculty of Medicine, University of Manitoba, Canada.

Research in Practice for Adults 2007, *Evidence cluster: Social care interventions for acquired brain injury*. Retrieved from <www.ripfa.org.uk/images/downloads/evidence_cluster_05.pdf>.

Robinson, E, Miller, R, Price-Robertson, R, Carrington, A, *Children and their families specialist practice resource*. Victorian Government Department of Human Services, Melbourne.

Room, G (Ed.) 1995, *Beyond the threshold: The measurement and analysis of social exclusion*. The Policy Press, Bristol, UK.

Schore, A 2003, 'The human unconscious: the development of the right brain and its role in early emotional life', in V. Green (Ed), *Emotional Development in Psychoanalysis, Attachment Theory, and Neuroscience: Creating Connections*. Brunner Routledge, New York.

Scott, D 2005, *Towards a national child protection research agenda and its translation into policy and practice*. Paper presented at the Australian Institute of Family Studies, Melbourne.

Shonkoff, JP, & Phillips, DA (Eds.) 2001, *From neurons to neighbourhoods: The science of early childhood development* (2nd ed.). National Academy Press, Washington, DC.

Smith, M 2004, 'Parental mental health: disruptions to parenting and outcomes for children', *Child and Family Social Work*. 9: 3-11.

Social Exclusion Unit 2001, *Preventing Social Exclusion*. Cabinet Office, London.

Social Exclusion Taskforce 2007, *Reaching out: think family*. Cabinet Office, London. Retrieved from <http://webarchive.nationalarchives.gov.uk/+http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_families.pdf>

Stanley, N & Penhalo, B 1999, 'The Mental Health Problems of Mothers Experiencing the Child Protection System', *Child Abuse Review*. Vol. 8: 34-45.

Stern, D 1985, *The interpersonal world of the infant*. Basic Books, New York.

Streeck-Fischer, A, & van der Kolk, BA 2000, 'Down will come baby, cradle and all: Diagnostic and therapeutic implications of chronic trauma on child development', *Australian and New Zealand Journal of Psychiatry*. 34(6), 903-918.

Stromwall, L, Larson, N, Nieri, T, Holley, L, Topping, D, Castillo, J, et al 2008, 'Parents with co-occurring mental health and substance abuse conditions involved in child protection services: Clinical profile and treatment needs', *Child Welfare*. 87(3), 95-113.

Summit, R 1983, 'Child Sexual Abuse Accommodation Syndrome', *Child Abuse and Neglect*. Vol 11, pp. 229 –235.

Sutherland, K, and Miller, R 2012, *Working with children who have experienced cumulative harm whose families have multiple and complex needs*. Presented at the Best interests case practice model professional development series, Royal College of Surgeons, Melbourne, 22nd May 2012.

Sved-Williams, A & Cowling, V (Eds.) 2008, *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives*. Australian Academic Press.

Thompson, M, & Kingree, J 2006, 'The roles of victim and perpetrator alcohol use in intimate partner violence outcomes', *Journal of Interpersonal Violence*. 21, 163-177.

Todd, F, Sellman, D, & Robertson, P 2002, 'Barriers to optimal care for patients with coexisting substance use and mental health disorders', *Australian and New Zealand Journal of Psychiatry*. 36, 792-799.

Tomison A 2000, 'Exploring FV: Links Between Child Maltreatment and Domestic Violence', *Issues in Child Abuse Prevention No. 13*. Australian Institute of Family Studies, Melbourne.

Tunnard, J 2002, *Parental drug misuse – a review of impact and intervention studies*. Research in Practice, Dartington.

Turnell, A, and Edwards, E 1999, *Signs of Safety A Solution and Safety Oriented Approach to Child Protection Casework*. W.W. Norton and Company.

Tymchuk, AJ 1992, Predicting adequacy of parenting by people with mental retardation. *Child Abuse and Neglect*. 16, 165-178.

UNICEF 2007, Child poverty in perspective: An overview of child wellbeing in rich countries. *Innocenti Report Card 7*. Florence: UNICEF Innocenti Research Centre. Retrieved from <www.unicef-irc.org/publications/pdf/rc7_eng.pdf>.

van der Kolk, B 1987, *Psychological Trauma*. American Psychiatric Press, Washington, DC.

van der Kolk, B 2003, 'The neurobiology of childhood trauma and abuse'. *Child and Adolescent Psychiatric Clinics of North America*. 12(2), 293-317.

van der Kolk, B, McFarlane, AC & Weisaeth, L (Eds.) 1996, *Traumatic Stress: The effects of overwhelming experience on Mind, Body and Society*. The Guilford Press, New York, London.

VicHealth 2004a, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence*. A summary of findings. Retrieved from <www.togetherwedobetter.vic.gov.au/resources/pdf/FinalReport_HealthCostsOfViolence.pdf>.

VicHealth 2004b, *The health costs of violence: Measuring the burden of disease caused by intimate partner violence. A summary of findings*. Department of Human Services, Melbourne. Retrieved from <www.vichealth.vic.gov.au/~media/ProgramsandProjects/MentalHealthandWellBeing/DiscriminationandViolence/IntimatePartnerViolence/ipv.ashxVicHealth>.

Victorian Aboriginal Child Care Agency 2006, *Working with Aboriginal Children and Families: A Guide for Child Protection and Child and Family Welfare Workers*. VACCA, Melbourne.

Victorian Government Department of Human Services 2008, *Aboriginal Cultural Competence Framework*. Victorian Government Department of Human Services, Melbourne.

Victorian Government Department of Human Services 2008, *Best Interests Case Practice Model: Summary Guide*. Victorian Government Department of Human Services, Melbourne. <www.dhs.vic.gov.au>.

Victorian Government Department of Human Services. *Child Development and Trauma Guide*. Victorian Government Department of Human Services, Melbourne. <www.dhs.vic.gov.au>.

Victorian Government Department of Human Services 2007, *Strategic Framework for Family Services*. State Government of Victoria, Melbourne <www.cyf.vic.gov.au/family-services/library/publications/strategic_framework>.

Victoria Police 2012, *Victorian Family Violence Trend Analysis Report 1999–2010 (Volume 5)*.

Waylen, A & Stewart-Brown, S 2008, *Parenting in ordinary families: Diversity, complexity and change*. Joseph Rowntree Foundation, York.

Winkworth, G, McArthur, M, Layton, M, Thomson, L, & Wilson, F 2010, 'Opportunities lost: Why some parents of young children are not well connected to the service systems designed to assist them', *Australian Social Work*. Vol. 63, No. 4, pp. 431-444.

World Health Organisation 2005, *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses*. World Health Organisation, Geneva. Retrieved from <www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf>.

Wu, N, Schairer, L, Dellor, E, & Grella, C 2010, 'Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders', *Addictive behaviours*. 35, 68-71.

