ATTACHMENT ET1

This is the attachment marked “**ET1**” referred to in the witness statement of Emma Toone dated 9 July 2015.

Appendix 1: Supplementary submission: Therapeutic responses for infants and children at escalating risk of family violence

Therapeutic responses for infants and children at escalating risk of family violence

Berry Street supplementary submission to the Victorian Royal Commission into Family Violence

Prepared by:
Emma Toone
Senior Clinician, Northern Family & Domestic Violence Service
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More Information
Julian Pocock
Director Public Policy and Practice Development
[redacted]

Introduction

This paper is written on the assumption that the Victorian Royal Commission into Family Violence will receive a plethora of responses from women and children's safety advocates arguing for coordinating and streamlining domestic and family violence safety, justice, family law, financial, housing responses to support women and their children to safely exit violent intimate partner relationships. This paper also assumes that many services will argue for healthy relationships and gender equality education in schools.

This paper aims to complement these arguments from an infant and child mental health perspective, identifying the gaps in services targeting children in their relationships where there has been, or is, the presence of family violence in families. In particular, the paper is written recognising the limitations to psycho-educational models of intervention for children and parents impacted by current, historical and intergenerational trauma. For this population, learning is possible only after the impact of trauma is recognised and addressed, to teach children to learn self-regulation through supporting the quality of children's care giving relationships (Perry 2006, Lieberman 2011, Schore 2014).

Repeated experiences of safety in relationships is a prerequisite for normal child development and for recovery from the trauma of family violence. The current paper identifies three target groups of children affected by violence who receive limited and in some cases no service responses that target their relationships. An initial literature review regarding the prevalence of family violence for these sub-populations is provided and a description of current service model responses and the limitations of these responses. The paper then goes on to recommend a way forward, identifying key model elements that would better address the problem, based on the evidence available, providing examples of local and international models which have demonstrated positive outcomes for these client groups.

The problem

This paper is concerned with three sub-populations of children affected by violence in Australia. These sub-populations will be defined by their residential arrangements within the following family constellations:

1. Infants and children residing in two-parent families in the perinatal period, where there is substantial risk of intimate partner violence occurring for the first time or escalating (e.g. during pregnancy).
2. Infants and children residing in recently separated families, with one residential parent, where there is immediate high risk of lethality from the non-residential parent toward the other parent and child (e.g. recent L17 assessed as high risk). This group are often in acute circumstances of changes in housing, schools, and as yet family law arrangements may not have been instigated.
3. Infants and children residing in post-separation families, having contact with a non-residential parent with a history of using violence and who are below the threshold for statutory intervention.

Many of these children do not feel safe in their relationships with their parents (Bagshaw et al., 2010) and the harms they may face will now be discussed.

Impact of family violence on child development; evidence-based treatment

The pervasive negative impacts of family violence exposure upon children have been conclusively established (Humphreys 2014). These include poor psychosocial and health outcomes and associated depression, anxiety, trauma symptoms, aggression, lower social competence, low self-esteem, fear and loneliness (Bedi & Goddard, 2007; Heugten & Wilson, 2008; Holt et al., 2008; Howell, 2011; Jaffe et al., 2012; Klitzman, Gaylord, Holt, & Kenny, 2003; Margolin & Vickerman, 2011; Spilsbury et al., 2008) (as cited

in Campo et al. 2014). Family violence exposure in childhood also tends to distort children's development. It may leave children in states of prolonged fear and dissociation (Perry 2006), compromising their cognitive functioning, academic outcomes, and peer relationships (Klitzman et al., 2003; Tuyen & Larsen, 2012) (as cited in Campo et al., 2014). Such children may in turn have significant difficulty in forming and maintaining relationships into adulthood (Lieberman et al. 2005).

Children's caregiving relationships are the primary resource for their development. These too are adversely affected by exposure to family violence (Lieberman et al. 2011, Humphreys et al. 2011). For example, a mother's representations of her child (the way she 'sees' her child) underlie her capacity to form a healthy attachment to her child, and these representations may be permanently distorted by family violence (Lannert, Levendosky, & Bogat, 2013). Less is currently known of the impact of family violence upon father-child relationships, however it would appear that these too are a vital resource for development (Edleson, 2007; Stover 2013; Fletcher 2011). Post-separation, it is also known that child wellbeing is compromised by ongoing conflict and the presence of fear within family relationships (Kaspiew et. Al., 2009; Kaspiew & Qu, 2013).

These factors would therefore need to be addressed by any intervention. Research has shown for instance, that dyadic mother-child interventions can be particularly effective in promoting children's recovery from trauma from family violence (Lieberman, Van Horn & Ippen, 2005; Lieberman & Van Horn 2009; Lieberman, Diaz, & Van Horn, 2011). Further discussion of these interventions will be provided below. There is as yet less evidence for dyadic father-child approaches. Indeed there are only minimal programs using assessment tools to allow us to predict the efficacy and even safety of such interventions (Groves et al., 2006; Stover 2013).

Prevalence

The current paper is concerned with the substantial proportion of children in Victoria, where historical, current or future violence risks exist in family relationships and who are below the threshold for statutory intervention. These children often do not feel safe in their relationships with their parents (Bagshaw et al., 2010) however interestingly it appears there is no specific data set for the numbers of children in Victoria living in these circumstances (Jenkin, 2015).

What we do know is that by conservative estimates, up to 23% of Australian children experience violence in their families (CFCA, 2013b) (as cited by Campo et al., 2014). In Victoria, 24,180 police incident responses to domestic and family violence between 2009–10 involved children (Victims Support Agency, 2011) (as cited in Campo et al., 2014).

Although in principle all children living with family violence are referred to Child Protective Services (CP), in fact if one of the parents (often the mother) separates from the parent in the home using violence (often the father), she is assessed as a protective parent and only 20% of referrals proceed past child protection intake (Stanley et al. 2011, Wood 2008, Irwin et al., 2012) (as cited in Humphreys, 2014). That is to say, if there is a protective parent, CP usually will not engage with family violence.

The ABS Personal Safety Survey (2012) found that one in four women experiencing family violence in their intimate partner relationships from adolescence onwards reported that they experienced violence for the first time during pregnancy. Emotional family violence is also common before, during and following family separation, although prevalence of physical family violence tends to diminish post-separation (Kaspiew et al., 2009). Many children living in separated families continue to be exposed to family violence post-

separation (Humphreys 2014, Kaspiew et al., 2009, Kaspiew & Qu, 2013). One in five parents hold safety concerns relating to their child's contact with the other parent (Kaspiew et al., 2009; Kaspiew & Qu, 2013). Furthermore even several years post-separation, a tenth of parents indicate that their relationship with their ex-parter is characterised by fear and high conflict (Kaspiew et. al 2009; Kaspiew & Qu, 2013). One study found that 39% of children with a history of family violence stated that they currently feel unsafe when in contact with their father and just under 10% did not feel safe with their mother (Bagshaw et al., 2010). The evidence suggests that whether arrangements are decided through court or mediation, most children will continue to have contact with both parents regardless of the presence of continuing family violence or safety concerns (Kaspiew et al. 2009; Qu & Weston, 2011).

Limitations of current service models

All children live in a matrix of interlocking relationships. This is significant for children exposed to family violence for two reasons:

- The harms alluded to above are embedded within these relationships. A comprehensive assessment of these relationships is needed to understand how these harms are unfolding.
- If the relationships can be understood and strengthened, the harms can be treated.

Currently there is no such comprehensive service delivery in Victoria. In fact services can at best deliver a fragmented assessment. An example of this fragmentation is that services are divided into responses for women, men, adults, or children (Morris et al., 2010; Humphreys, 2014). The effect of this fragmentation becomes even more apparent when child deaths are examined. A key finding in an analysis of child death reviews in Victoria (Frederico et al. 2014) is that when children are exposed to family violence, barriers to the sharing of case data across service sectors compromise assessment including that of risk. For example, adult psychiatrists may not be able to provide expert opinion on parenting capacity (Duncan & Reder 2003) (as cited in Frederico et al.2014). Also, child-trained practitioners may be unable to assess family violence risk, and may lack confidence and skill in working with mother-child and father-child relationships where there is family violence (Frederico et al., 2014).

In recognition of this fragmentation recent large scale reviews have recommended a broadening of service focus. The National Plan to Reduce Violence against Women and their Children and the Protecting Victoria's Vulnerable Children Inquiry both recommend that adult-focused services need to increase their capacity to respond to the needs of children at risk and that child-focused services also need to improve their capacity to identify women and children at high risk from family violence.

There are various services and programs already attempting to integrate adult and child-focused crisis responses for families where there is family violence, such as the Risk Assessment Management Panels (RAMP) piloted by Berry Street Northern Domestic & Family Violence Service and currently being rolled-out across Victoria (Hunter & Price-Roberston, 2014). RAMP very appropriately assesses the needs of the highest risk population and coordinates an appropriate crisis response. However clinical interventions targeting children living in families where there is pregnancy, high risk incidents and post-separation violence are lacking.

There are currently several candidate services to address this population:

Sexual Abuse Services such as Gatehouse or Children's Protection Society, however their focus is upon sexual abuse and they do not have a comprehensive approach to assessing family violence.

Berry Street Northern Domestic Violence Service Turtle Program and other equivalent programs at the Australian Childhood Foundation, Anglicare and Women's Health West. They are funded to work with women and children affected by family violence but not funded to work with fathers. This omission is important because the child's relationship with the father does affect development but cannot be addressed.

Infant, Child and Youth Mental Health Services, who are reluctant to address the mental health of children whilst contact with a violent parent is still occurring, and who usually advise that child protection or legal avenues would be more appropriate. This therefore excludes the population under consideration.

Berry Street Take Two, who are funded only to work with children who are statutory clients. These children may be at risk from family violence in out of home care, but not from their parents, therefore Take Two cannot address the (non-statutory) population we are considering.

Berry Street family services programs, youth services and child contact centres. These services are already engaging with children, women and men who use violence, however they currently lack expertise in conducting comprehensive assessments of family violence.

A way forward

Bearing in mind this population of children, the threats to their development, and the current lack of appropriate services, the question is how a best practice model might be developed.

Models of intervention that focus on the individual child and their recovery after family violence are needed. The required features of these models are:

- Models that integrate family violence risk assessment with child-parent relationship assessment. In regards to the latter, this would look at a child's needs and the parent's capacities for change and reflection.
- Models that aim to safely enhance the child's relationship with both parents without escalating family violence risk.

These models must focus on windows for clinical intervention in the life cycle of violence in families. We turn to considering three such windows for three sub-populations of children affected by violence in Australia, below.

Children being born into families where there is risk of intimate partner violence occurring for the first time, or where violence is escalating during the perinatal period.

A recent review of family violence prevention, early intervention and response services found that in Australia there is limited evidence for the efficacy of programs for children under 8 years (Campo et al. 2014). There is also a dearth of literature in general documenting perinatal treatments for women subjected to trauma or family violence (Lavi et al., 2015). However there is a growing body of infant mental health literature providing evidence that persuasively argues for the clinical effectiveness of targeting the mother-child relationship in the perinatal period, during infancy and early childhood with families (Emde & Leuzinger-Bohleber, 2014). Where the mother is the primary caregiver, her relationship with her child is the single most important developmental resource for the child throughout childhood (Zeanah, 2009). The quality of this attachment relationship predicts children's IQ at entry to preschool (Busch & Lieberman

2010, Levendosky et al., 2011). Family violence during pregnancy is particularly associated with negatively impacting the quality of the mother-child attachment relationship (Lannert & Levendosky, 2013).

Studies suggest that brief attachment interventions (three to six-months in duration) with mothers and children exposed to family violence can be effective in enhancing the quality of mother-child attachment relationships and child development outcomes (Lieberman et al. 2011, Bunston et al., 2014, Lavi et al., 2015). We will briefly discuss two models of intervention specifically targeted for families in the perinatal period where there has been IPV, with promising outcomes.

Two recent pilot studies examined the potential impact of a perinatal adaptation to Child-Parent Psychotherapy (CPP), an evidence-based treatment for mothers and children affected by family violence, on maternal functioning, the gateway to the quality of the parent-child relationship (Lieberman et al. 2011, Lavi et al., 2015). These models are of particular interest due to the fact that they are informed by clinical interventions targeted for mother—preschooler dyads who have experienced family violence demonstrating efficacy in reducing PTSD symptoms in both mothers and children, and decreased behavioural difficulties in the child at the conclusion of treatment (Lieberman & VanHorn, 2008).

The focus of Perinatal CPP is to focus on redressing the negative impact of family violence on parent-child attachment relationships, through focussing on linking family violence risk assessment and management, concrete assistance with the problems of living, and targeted clinical intervention with mothers and their babies beginning when women are approximately 30-weeks pregnant until the baby is aged up to 6-months. If mothers wish for fathers to be involved in treatment, fathers need to participate in an assessment which ascertains his capacity for "self-reflection and remorse, potential for violence and lethality, and commitment to parenting" (Lieberman et al., 2011, p. 57). The goal of the intervention is to enhance mother-child relationships impacted by family violence and curtailing the intergenerational transmission of trauma and maladaptive developmental responses in children (Lieberman et al., 2011, 49).

This is achieved through therapeutic modalities such as the provision of reflective developmental guidance and insight-orientated interpretations delivered by trained clinicians. The clinician also administers psychometric instruments in collaboration with the mother, in order to measure the stresses she has been subjected to and the impact these stresses have had upon her capacity for maternal reflection. The Perinatal CPP intervention reflected the results of prior studies on CPP (Lieberman & VanHorn, 2008); decreased PTSD and maternal depression symptoms in a brief time-frame (6-9 -months). The study demonstrates the promise of a dyadic, attachment-based intervention in healing the distorting impact of family violence on mother-child relationships in the perinatal period among an at-risk and underserved population (Lavi et al., 2015).

It is noteworthy that from an international perspective, Melbourne is viewed as one of the leading centres in the world for the development of infant-parent psychotherapy interventions (Paul & Salo, 2013). At the recent 2014 World Association for Infant Mental Health in Edinburgh, there were more Australian registrants than any other country, including the host country (Goodfellow & Toone, 2014). There is much interest in infant mental health, in part because infant mental health training equips clinicians to work with trauma in children and adults. In fact, one child-trauma clinician and researcher from the USA, Dr Bruce Perry, has designed a model of assessment (the Neurodevelopment Model of Therapeutics) based on clinical interventions delivered by infant mental health practitioners over the past three decades (Perry 2006). Melbourne is also a training centre for the Newborn Observation Training at the Royal Women's Hospital in Melbourne, this is one of the assessment instruments used in the above Perinatal CPP process

to assess the newborns and simultaneously promote the mother's understanding and joy in their baby's capacities (Nugent et al., 2007). In fact, a brief, attachment intervention drawing on the NBO and delivered by non-therapists to adolescent mothers (many with histories of statutory intervention) as part of routine maternity care has been trialled at the Royal Women's Hospital with promising results (Nicholson et al., 2013). This intervention in itself may be a model which can be adapted for high risk adolescent mothers who have experienced family violence and reside in residential care and post-care populations.

The above section discussed an evidence based intervention that is documented to provide positive change in mother-child relationships after family violence, decreasing trauma symptoms in mothers and children, and promoting early childhood development. The model is unique to an Australian context because it integrates family violence risk assessment with parent-child relational assessment and intervention with mothers, with clear inclusion and exclusion criteria for working with fathers. The section above also further suggests that due to the level of expertise in infant mental health in Victoria, such an intervention may be highly transferrable to the Australian context and it would be argued, warrants further consideration as a way forward for supporting at-risk mother-child relationships during the perinatal period.

Children residing in recently separated families, with one residential parent, where there is immediate high risk of lethality from the non-residential parent toward the other parent and child (e.g. recent L17 assessed as high risk). This group are often in acute circumstances of changes in housing, schools, and as yet family law arrangements may not have been instigated.

It is argued that there is an urgent need for effective interventions to decrease the risk of post traumatic stress disorders developing in children and youth after experiencing or witnessing physical assaults (Berkowitz et. al 2011). The current paper also argues that such interventions are urgently required for mothers, given they are often the primary caregiver and protective parent for the child in the majority of family violence situations in Australia (Humphreys 2014). Berkovitz et al., (2011) define "secondary prevention as an intervention introduced when there are early distressing symptoms that indicate risk for subsequent psychiatric disorder" (p. 676).

In preparing for the current paper and submission, the author communicated with colleague from the UK, Dr David Trickey, Consultant Clinical Psychologist and Manager, Specialist Assessment and Treatment Services at the Anna Freud Centre (Trickey, 2015). Tricky is one of UK's leading researchers and clinician in responding to children who have witnessed or experienced a recent, serious physical assault or traumatic bereavement, where for example a father has killed the child's mother. Tricky has recently undertaken a Churchill Fellowship, the report of which is yet to be published, but has communicated that he will be recommending that the following model of intervention - the Child and Family Traumatic Stress Initiative (CFTSI) should be employed for children and parents after a potentially traumatic event (PTE) as a matter of routine (Berkowitz et al., 2011). The focus of the CFTSI is informed by findings that indicate the role of family support as a primary protective factor for children exposed to a PTE, and delivers a brief (four session) parent-child intervention within 30 days of exposure to a potentially traumatic event (PTE). This intervention targets an older age-group of children (7-17-years), with a focus on adolescence and youth at risk of developing PTSD. Youth who received the CFTSI intervention had significantly lower posttraumatic and anxiety scores than comparison group and were 65% less likely to meet criteria for PTSD at the 3-month follow-up.

Drawing on the evidence referred to in the above section on dyadic and perinatal clinical interventions, and paralleling the findings immediately referred to in the CFTSI, the Berry Street Northern Family & Domestic

Violence service has previously trialled some brief child-parent psychotherapeutic interventions (one to three sessions) within a family violence risk management framework, for mothers and children who are at high risk of lethality and may have witnessed a recent serious physical assault (O'Halloran & Toone, 2013). This intervention was achieved by embedding a psychoanalytically-trained infant mental health clinician and child psychotherapist within a family violence service, with the capacity to offer secondary consultation to specialist family violence practitioners with a focus on child development and mother-child attachment, and brief dyadic intervention directly to mothers and children as indicated. This service was aimed at complementing the Risk Assessment Management Panel pilot, and whilst anecdotally suggesting positive results, has yet to be evaluated.

Bunston (2014) is currently researching the effectiveness of brief therapeutic interventions in refuge settings and it is understood that she will be submitting a separate submission to the Royal Commission detailing this work.

In summary, there is a lack in current service delivery specifically targeting populations of children and youth at risk of developing symptoms of PTSD after a potentially traumatic event. The application of brief models of dyadic intervention with mothers and children after violence have demonstrated clinical effectiveness and it would be argued warrant further consideration as a way forward to intervene with children, youth and their mothers to support the mother-child relationship as a resource of safety for children after frightening events.

Children residing in post-separation families, having contact with a non-residential parent with a history of using violence and who are below the threshold for statutory intervention.

This population is another particularly hard to reach population, due to the fact that these children are often in contact with both parents and currently no single clinical service is able to assess and deliver an intervention which promotes the child's relationship with both parents, whilst assessing and managing family violence risk. The Child-Parent Psychotherapy (CPP) model of intervention has been previously mentioned above, when considering the Perinatal CPP intervention. There is evidence that the CPP intervention, a psychotherapeutic approaches of 12-months duration can be particularly effective in promoting the quality of the attachment relationships between mothers and children who have experienced family violence (Lieberman, Van Horn & Ippen, 2005; Lieberman & Van Horn, 2009).

It is worth considering a recently published pilot study trialling an intervention for fathers called 'Fathers for Change' (Stover, 2013). This study recognises the high percentages of men who are mandated to intervention programs for family violence who are fathers, echoing the previously mentioned situation in Australia where regardless of whether child contact arrangements in separated families are decided through court or mediation, most children will continue to have contact with both parents regardless of the presence of continuing family violence or safety concerns (Kaspiew et al., 2009; Qu & Weston, 2011). Stover is trained and has contributed to the development of both the CPP and CFTSI treatment models for children and their mothers who have experienced family violence (Stover 2013; Berkowitz et al., 2011).

Identifying that "there are currently no evidence-based treatments that address co-morbid substance abuse and domestic violence perpetration with emphasis on paternal parenting for fathers" (p. 65) the Fathers for Change Intervention combines what in Australia we would refer to as Men's Behavioural Change models, with child-parent attachment models to focus on three phases of intervention: abstinence from aggression and substance abuse, co-parenting, and forming a parenting and father-child relationship.

Treatment is dictated by the mother's level of comfort and her consent for the involvement of her child before an assessment is undertaken, with the child and father-child relationship assessed to determine the father's capacity for reflection and the child's sense of safety. The intervention which comprises of 16 sessions delivered within a 3-4-month period, demonstrated that all participants non-violence sustained by all participants throughout the treatment period and 80% becoming abstinent to substance abuse. The limitation of this intervention is that is does not measure outcomes for the child, as against Lieberman's Perinatal

CPP and CPP models which measure child behaviour, mood and post-traumatic stress symptoms at the end of treatment. It is known that men's roles as fathers may be a potent motivator for change (Stover 2013), and this intervention, focussing largely on post-separation populations of fathers combines a family violence risk assessment with parent-child relational assessment, and recognises the need in future studies to link specific clinical interventions for children and women to men's behaviour change models of intervention.

Post-separation, it is also known that child wellbeing is compromised by ongoing conflict and the presence of fear within family relationships (Kaspiew et al., 2009; Kaspiew & Qu, 2013). It is argued that further clinical interventions specifically targeting children in post-separation populations, drawing on the best features of Lieberman's CPP model and Stover's Fathers for Change Models of intervention, must be investigated and implemented in Australia to safely assess and enhance these children's relationships with both parents without escalating risk and in so doing, support children's recovery from the impact of family violence and development into adulthood.

Recommendation

That the State Government, in partnership with key stakeholders including specialist family violence and infant and child mental health practitioners, develop best practice models of intervention that focus on the individual child and their recovery after family violence with features that include:

- Integrated family violence risk assessment and child-parent relationship assessments of a child's needs and the parent's capacities for change and reflection
- Therapeutic supports and interventions that safely enhance the child's relationship with both parents without escalating family violence risk for any affected family members

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