Royal Commission into Family Violence

WITNESS STATEMENT OF SUSAN ANNETTE WEST AND TIMOTHY GERARD MOORE

I, Susan (Sue) Annette West, Associate Director of the Centre for Community Child Health, Royal Children's Hospital and the Murdoch Children's Research Centre at 50 Flemington Road Parkville in the State of Victoria, and Timothy (Tim) Gerard Moore, Senior Research Fellow of the Centre for Community Child Health, Murdoch Children's Research Centre at 50 Flemington Road Parkville in the State of Victoria, say as follows:

1. We are authorised by The Royal Children's Hospital (**RCH**) and Murdoch Children's Research Institute (**MCRI**) to make this statement on their behalf.

2. We make this statement on the basis of our own knowledge, save where otherwise stated. Where we make statements based on information provided by others, we believe such information to be true.

Current role

3. Sue is Associate Director, Centre for Community Child Health at the RCH (**CCCH**) and Senior Manager, Policy and Service Development at the MCRI. She has held these positions since November 2012. In these positions she is responsible for wide-ranging activities concerned with early childhood policy, translation of research into practice, workforce development, service improvement and evaluation.

4. Sue's group undertakes, synthesises and translates research so that it can inform policy, service delivery, professional practice and parenting and includes the award winning Raising Children Network in partnership with the Parenting Research Centre; translation and knowledge exchange projects; training and development activities; service systems innovation projects and policy related research.

5. Sue has a specific interest in generating and exchanging knowledge to support the efforts of policy makers, programme managers and practitioner networks to design and implement more effective local area strategies that improve children's wellbeing. Sue provides overall direction and leadership for the programme planning, implementation and evaluation support delivered by the group.

6. Tim is a Senior Research Fellow at the MCRI and CCCH. He has held this position since May 2000. In this position he leads a small Research and Policy team that synthesises research evidence, providing advice to state and federal government and non-government agencies on best practices in early childhood, and conducting research and project work in generalist and specialist early childhood services and in service development.

Background and qualifications

7. Sue has a BA in Arts and a Masters in Social Policy. Prior to joining the Centre for Community Child Health in 2011 she spent ten years in Universities including the School of Population Health, University of Melbourne where she investigated and supported the development and use of community wellbeing indicators in planning, policy development and citizen engagement. Sue's employment history also spans roles in academia, local government and the non-government sector.

8. Tim trained as a teacher and psychologist at the University of Melbourne, subsequently completing his Doctoral studies at the University of Surrey on self-esteem and self-concept in children. Tim has worked as an educational and developmental psychologist for over 30 years, both in Australia and England, in a variety of mainstream and specialist settings. In particular, he has had a long involvement in the development and delivery of early childhood intervention services for young children with developmental disabilities and their families. In his current role, he has been the principal writer on numerous CCCH reviews, reports and policy briefs, and is a frequent keynote and workshop presenter.

The Parent Engagement Resource

9. The Parent Engagement Resource (**PER**) is a tool that Tim designed with his team at MCRI. A detailed overview of the PER is attached to this statement and marked **'SW 1'**.

10. Work was initially started on the PER over 10 years ago as part of Commonwealth funding that produced the CCCH Platforms Project. Due to lack of funding, the PER was not trialled until the Department of Education and Early Childhood Development (now the Department of Education and Training) funded a feasibility study in 2011/2012.

11. Subsequently MCRI received a significant Commonwealth grant from the former Department of Families, Housing, Community Services and Indigenous Affairs to undertake a national randomised control trial in 10 Communities for Children sites across Australia in 2013/14. This is discussed in further detail below.

12. The PER is designed to support front line practitioners who work with the families of young children such as maternal and child health nurses (**MCHNs**), community paediatricians or those in a universal service provider such as general practitioners (**GPs**). It aims to assist those front line practitioners with early identification of family psychosocial factors that are known to adversely affect a child's wellbeing and development.

13. The PER includes a training package and 16 questions that can assist practitioners to respond to parent's concerns about any psychosocial factors that might be adversely affecting their child's development and wellbeing. The 16 questions consists of two introductory questions, 12 concern-based questions and two closing questions:

13.1 The introductory questions focus on engaging the parent through a conversation about their baby/child and their family. These questions are designed to assist workers to establish a relationship with the parent;

13.2 The following 12 questions address:

- Psychosocial concerns that if not addressed are known to impact negatively on children's development and wellbeing (for example, social supports, networks, isolation, money, housing and employment are all identified as risk factors). These psychosocial concerns are discussed in further detail below;
- Issues of parenting, mental health and the physical care of child; and
- Actual neglect, drug and alcohol issues, repeated disagreements or conflict and family violence.

13.3 The two closing questions aim to complete the conversation in a positive light and support an ongoing parent/practitioner relationship.

14. The criteria for selecting the 12 psychosocial concerns were that each had to be a key factor that is known to have an adverse effect upon family functioning and

parenting and hence upon child care and wellbeing, and for which there is some known treatment. One psychosocial concern is family violence, but many of the other concerns addressed by the PER are risk factors for family violence. This means that the PER has the capacity to identify family violence that is already occurring, either on its own or with other issues. It also has the capacity to identify risk factors and to enable those factors to be addressed before family violence occurs.

15. The questions are all framed in a way that focuses on the child rather than the parent. By tapping into parental concerns about the child rather than directly challenging the parents about their own behaviour, the PER increases the likelihood of disclosure. It is also made clear to the parent during use of the PER that they do not have to answer the questions if they do not feel comfortable doing so at that stage.

Early identification of factors leading to violence

16. In human services in general, the usual response to complex issues is to treat the presenting problem rather than address the conditions that triggered the problem. In the case of family violence, this takes the form of efforts to support and protect those at risk, or to work with perpetrators to reduce or eliminate violent behaviour. Such efforts are labour intensive, costly, and (at least in the case of treatment programs for perpetrators), not very effective. While interventions that address presenting problems are important and must continue to be provided, it is also important to try to reduce the incidence of family violence. This can be done in two main ways through:

    16.1 Early interventions; and

    16.2 Efforts to address the conditions that trigger family violence.

17. Early interventions are interventions provided before problems have become full-blown and require a treatment response. This is a more cost-effective approach as well as having the potential to protect children and families from the toxic effects of escalating family violence. One of the challenges in providing such services is how to identify those experiencing problems that could develop into family violence. This is where the PER can play an important role: by helping parents share their concerns about family violence and other issues with front-line practitioners, the PER can be instrumental in helping families access services to help them address them and prevent them getting worse.

18. We also need efforts to understand and address the underlying conditions that are triggering family violence. The conditions under which families are raising young children have changed dramatically over the last few decades. While many families have benefited from these changes, those with fewer resources find these conditions stressful and are more likely to be exposed to multiple stressors and be experiencing problems in health, mental health and behaviour.

19. Factors that contribute to family stress and therefore increase the likelihood of family violence include social isolation, parenting difficulties, health and mental health problems, housing insecurity, financial concerns, unemployment, non-family friendly work conditions, cultural and language barriers, lack of access to services, and long or stressful journeys to work. These conditions may accumulate in areas of intergenerational disadvantage, but may also be present in growth corridor developments due to lack of social support, child and family services, and infrastructure. Unless these underlying conditions are addressed, the incidence of problems such as family violence will not change. Again, the PER can play an important role in identifying many of these concerns and helping families gain access to services to help them manage the issues more effectively.

20. Wider social and cultural beliefs can also provide conditions that promote family violence and therefore may also be an important target for intervention. Within the general community as well as within specific cultural groups, gender inequities have been identified as a contributing factor. A public awareness campaign to change attitudes towards women and to send the message that violence is not acceptable would be an appropriate start.

21. As well as gender inequality issues, there are other precipitating factors such as social disadvantage, mental illness, alcohol and drug addiction and attitudes towards violence. Gender inequality may not lead to violence if these other factors were not present and stressing families in other ways. We therefore need to consider how to reduce the stressors on families and to identify the things that build family and personal strength, competences and resilience and promote positive parenting, family and community functioning.

22. The PER aims to remove the stressors on families as it is designed to enable front line practitioners to identify psychosocial factors that we know compromise parenting or family functioning. The PER identifies 12 psychosocial factors, one of which is family violence, but any of those 12 factors could lead to family violence, or child

abuse or mental health problems, if not addressed. Those factors could then feed into one another and escalate.

23. Through our analyses of the research evidence and through our direct engagement with services and service systems, we have come to the conclusion that addressing the major complex issues of the day – such as child protection, family violence, obesity, and properly preparing children for school – requires a systemic multi-level approach involving programs that:

23.1 Address presenting problems;

23.2 Seek to intervene early to prevent problems from escalating; and

23.3 Address the underlying conditions that trigger problems,

in order to reduce the incidence of them occurring at all.

24. Efforts to reduce complex problems that focus most efforts on one level only (for example, on treating presenting problems) will not produce sustained results. Moreover, there is huge financial wastage if a system focuses on cleaning up issues once they have manifested rather than investigating what causes those issues.

Use of the PER

25. As set out above, the 16 questions that form the PER are all framed in a way that focuses on the child rather than the parent. Each question follows a format which first provides information about factors that can be harmful for children's development, and then asks the parent if they have any concerns that their child is being affected by a particular issue. For example, with regard to family violence, the worker would ask

> *We have learnt that children's development can be affected or harmed by repeated exposure to frightening behaviour. This might be threats, bullying, yelling, screaming, putting people down, hitting, slapping, kicking or punching.*
>
> *Do you have any concerns that your child might be seeing or hearing behaviour that frightens them?*

26. The wording of the above question allows workers to approach a highly sensitive issue by informing that parent that family violence is actually damaging for their child.

It also provides an important contrast to formats used in other tools which focus on parents' behaviours and which parents often find to be intimidating and accusatory. The PER takes the emphasis away from the adult and, instead of challenging their behaviour, taps into parental concerns about their children.

27. As well as the 16 questions, practitioners are provided with a decision-making algorithm to accompany each question. A document setting out the algorithms for practitioners is attached to this statement and marked **'SW 2'**. The algorithm enables practitioners to operate with a flow chart which informs them what to do with each response. Essentially, practitioners should not be asking questions if they do not know how to respond to the answer and who/which services to refer parents to.

28. The algorithms encourage practitioners to discuss and explore the type of action the parent may want to take. It is the parent who ultimately decides. Once a decision has been made, the practitioners refer the parent to the relevant services. The PER assumes that practitioners have a level of knowledge of services and relationships with other practitioners. Prior to using the tool, practitioners are required to identify locally available services.

29. This implies that practitioners are working with integrated services. This is important not just for family violence but to build a coherent network of services which address all of these underlying issues and the risk factors that influence a family's capacity to raise their children as they, and we, would wish they could. This coherent network should include, for example, drug and alcohol services, parenting resources, financial counselling, mental health services and housing.

30. The PER helps practitioners to identify a whole range of risk factors because we know that if one is present, it is likely others are too. It becomes a tool for working across a system where all of the services are connected and understand each other's roles. Services that are better integrated and connected are integral.

31. Parents and practitioners do not always have to do something about the problem once it has been identified. Merely having talked about it and having a trusting relationship with someone who knows about the problem can sometimes help to manage it and reduce the likelihood that it will spill over and interfere with their parenting.

32. The PER also focuses on working better with the actual service users. The notion of involving service users in co-designing and having a significant input into the shape

and functioning of services has become increasingly important. Essentially, parents need to be comfortable with the questions in the PER, to follow the format and find it informative. We have found that in many cases, parents welcome a practitioner asking about these issues and showing that they are interested and concerned about the family as a whole and not just the individual service that is being offered.

33. The PER is built on best practice and family-centred practice and, because it ensures that practitioners ask sensitive questions in a way that is respectful and informative, practitioners then behave in a respectful and family-centred way. Thus, the very format of the PER operationalises family-centred practice and has the capacity to change people's practice. Many practitioners think they are being respectful and family centred but the PER ensures they are.

34. Another important element of the PER is the notion of practitioners using a checklist. This is important because although practitioners often ask parents about psychosocial issues, our research indicates that they do not always ask about all issues and risk factors because they are not using any systematic method of doing so. Moreover, every professional has blind spots and issues that they find difficult to talk about, and therefore are less likely to explore with parents. As a consequence, they either consciously or unconsciously steer clear of those issues. The PER acts as a way to systematically check all 12 areas relating to key factors that are known to have an adverse effect upon parenting or family functioning and hence upon child development and wellbeing, and for which there is some known treatment.

35. In the work that we have undertaken in evaluating and testing the PER with MCHNs in Victoria, it is clear that the area of family violence is one they feel really uncomfortable talking to clients about. MCHNs have informed us that the PER is a tool they, and parents, are comfortable to use.

Connection between services

36. As set out above, services that are better integrated and connected are integral. There needs to be better connection behind the use of a tool like the PER. Community quality and improvement methodology shows that there are things that can be done within service networks that result in improvement across the community as a whole. Place-based approaches have the capacity to build integrated networks and shift outcomes significantly.

37. CCCH has been involved in various place-based approaches designed to build integrated service networks, including the *Blue Sky* project in Melton South, and a new *Best Start* project.

38. The *Blue Sky* project aimed to re-engineer the health, education and welfare service delivery system for children aged 0 to 8 and their families in the outer western metropolitan locality of Melton South. It was implemented in two phases over five years, from 2009 to 2014, and applied healthcare re-design (phase one) and quality improvement (phase two) approaches.

39. The initial re-design phase undertaken by the Department of Education sought to better understand community needs and service gaps, and identify evidence-based strategies and processes to improve the effectiveness of the service system. The second phase delivered by CCCH involved trialling quality improvement methodology to implement the changes identified in phase one. Grounded in improvement science, Melton South agencies were supported to transform service delivery practices through innovative learning, measurement and evaluation methods. Agencies were supported to test small, incremental changes that did not require additional resources or funding and were encouraged to think as a system to positively influence population outcomes.

40. The second phase of *Blue Sky* also involved collecting and relaying monthly feedback from families about service experiences in the community to guide further action. An evaluation of the second phase of *Blue Sky* indicated changes had been initiated as a result of the quality improvement approach. The evaluation also provided insight into the feasibility, effectiveness and transferability of these methods to other collaborative community initiatives.

41. *Best Start* has been a key initiative of the Department of Education since 2001, designed to improve the health, development, learning and wellbeing of all Victorian children (0 to 8 years). CCCH is now undertaking a new project to improve collaboration service delivery improvement in *Best Start* sites utilising the continuous quality improvement approach trialled in the *Blue Sky* project. This will involve the development of a training and mentoring package to support partnership/network-based collaborations, a review of current outcome indicators of the Best Start program, and the facilitation of a measurement and change process.

42. Services that address issues relating to family violence, and other child and family outcomes, require better coordination and connection. Testing, trialling and reflection methodology is useful to enable services to develop relationships with each other and to make incremental change that can be measured and shown to make a difference rather than developing a whole new program or service.

43. We need to ensure that not only is the system integrated but also that we are providing the right kind of services for parents, particularly in the first five years of their child's life. We need to consider where parents go on a regular basis with their child that they both look forward to. There is a lack of places such as playgroups and parent's groups in our society today. If we build integrated child and family centres where parents can spend time and which have the capacity to run playgroups, we will start to have a place that can meet this role and build networks between parents which is one of the 12 things the PER seeks to do.

44. As noted earlier, rapid social change has profoundly altered the conditions in which families are raising children. For example, communities are now structured differently. Doctors, libraries, shopping centres and schools are no longer necessarily within a five or 10 minute walk. Parents no longer have people around them who recognise and support them. Many people do not have secure employment. When we look at creating solutions, we need to consider not only the service system but also community support – where families go, how they get there, what the public spaces are like, what opportunities do families have to meet other families and build their own supports to help them be more effective parents, what community support is there for fathers (particularly as men are the major perpetrators of family violence), and what do those fathers do if they are unemployed.

45. In order for practitioners to properly refer parents when working through each issue in the PER, they need to be aware of the key services in their areas, where they are located and who works there. We need to identify a way to unify the service system so that this knowledge and information is shared and a practitioner using the PER is then acting on behalf of the whole system. At the moment the service system tends to be designed for the convenience of the service system rather than for the families. Professionals decide where services should be located, what the buildings should be like, and what hours they should operate. We need to start tuning into what service users deem is most important, tailoring the service to the family's circumstances and building their capacity to do a better job as parents. The PER contributes to that by

informing the parent that it is their decision as to what action they want to take once an issue is identified.

Place-based initiatives

46. One of the key strategies for building those service networks centres on notions of place-based initiatives. This means that everyone in a geographical area is involved – services, government, non-government services, faith based groups, businesses and parents and other community members – and come together to agree upon priorities and what they want for that community and develop an action plan where everyone has a part.

47. The focus is therefore on things that the community considers are important, and which are agreed on as the main outcomes areas for change. They are then measured in a 'data dashboard' approach (a simple graphic way of documenting progress towards outcomes) so that everyone has a part to play, and is contributing and working towards the same goal. If done properly, this enables a holistic approach, allows a response to community priorities rather than top down priorities, and facilitates programs bring tailored to community needs. Having said that, we are still learning how to implement place-based approaches successfully, although there are some good local examples like *Go Goldfields* and the *Blue Mountains Stronger Families Alliance*. We are currently working with a number of initiatives of this kind.

48. *Go Goldfields* is an innovative alliance of organisations in the Central Goldfields Shire focusing on how they work together to deliver locally relevant solutions to social issues affecting children, youth and families. The program has developed a series of shire-wide, community-driven approaches to improve social, education and health outcomes for children, youth and families.

49. Place-based approaches are sometimes called *collective impact* initiatives. The idea is that all key stakeholders are working together on a priority issue or set of issues and aligning their efforts around that. It is a whole of system approach. For example, *Go Goldfields* has created a particular clustering of services and other interests working together to shift outcomes by bringing in new resources such as speech pathologists to assist with language and literacy, but also changing the way those services work with children and families. As a result, there has been a demonstrated improvement in literacy and language levels for children starting school. The initiative has lifted the bar for all children who live in the Central Goldfields Shire Council.

50. The *Blue Mountains Stronger Families Alliance* is a network of government, non-profit and voluntary organisations working together to support to families across the Blue Mountains. Partners work within a strengths-based, relational framework that focuses on the intersection of significant relationships, to promote the wellbeing of children and their families. They have developed a collaborative approach to case management that is used in their work with each other and across the broader service sector. Member organisations' practice is also underpinned by the belief that children's wellbeing and that of their families, is supported by strong connections to their community. The Alliance's Child and Family Plan was developed by the Alliance as a tool to help its members to think holistically and act as one. The Child and Family Plan has a triple focus: strengthening families through neighbourhood service systems, moving children and the families beyond vulnerability, and creating child-friendly communities.

51. There is a range of enabling factors for such initiatives including funds for a core group of people to take a lead role and be facilitators in bringing the core service networks together. In the case of both *Go Goldfields* and the *Blue Mountains Stronger Families Alliance*, it is the local government, but any service provider could potentially act as the lead agency. That facilitation role then enables the service redevelopment to occur.

Place-based networks and family violence

52. If a place-based initiative in a community identified family violence as a problem to be addressed, the approach to dealing with it would depend upon their understanding of what factors contribute to family violence in their community. Only if the community understands why family violence occurs will it be able to decide what can be done to address it and what that community can offer, whether it be Men's Sheds, parenting programs, financial counselling to reduce stress, or assistance with housing.

53. A place-based initiative could invite each of the component services to the system to bring what they have to the table so that they can be deployed to address the particular issue. This is as much of a challenge as building networks and partnerships which is hard enough itself. It is important to recognise that it is not possible to tackle all factors simultaneously, so the community must decide where to focus its efforts.

54. It is also important that the professional service system refrains from trying to fix problems by deploying heaps of services, but instead engages with the community in

deciding what they need. Since it is not always possible to know beforehand what interventions or strategies will succeed in a particular situation, interventions should be introduced on a trial and error basis, and be prepared to 'fail quickly' – that is, if feedback indicates that the strategy is not working or not being taken up by families, we need to explore using a different strategy.

55. That is an entirely different way of delivering services to the traditional model, which is to lock in services and funding for 12 months or more, and not allow the flexibility to enable rapid redeployment of resources to follow community needs and of preferences when necessary. Co-construction and partnering with the community is a huge challenge for services and, particularly government, as it appears to be a loss of control when in fact it is actually a gaining of more control.

56. If we get this approach right, it enables us to tackle problems at an earlier level to reduce the incidence and moves away from trying to fix problems once they have arisen. In the family violence space, evidence as to the success of treatment programs for perpetrators is not good. We therefore need to think about how to reduce the incidence and prevent the violence occurring. Place-based community-partnering approaches have the capacity to do that.

57. Government needs to allocate some funding to local areas to develop their own strategy to links in with the services available in that area. The services not only have to be linked but also need to align to the needs identified by the local community. Services must be funded in a way that enables them to be freed up to work this way.

58. Also, services are not currently well mapped in Victoria. As discussed above, the PER requires practitioners to have a relationship with people and services that they are able to refer to. They need to be familiar with them, have used them previously and know where they are located. Everyone needs to be part of a single system. It really is stunning how few practitioners and services in the same area do not know each other.

59. A state government mapping of services would make such a difference. This could be undertaken in partnership with the Commonwealth government as a significant service funder. The initial start could be funding for an actual ability to map services state wide and according to local areas. This would provide a basis from which local organisations can identify other service providers to connect with.

An integrated family violence service system

60. We have undertaken a lot of work in building systems with integrated family child services. The key is the 'one door' notion which means that people do not have to tell their story over and over again. A really challenging question to consider is whether the PER could address one of the challenges of the system by enabling there to be one person who had the strongest relationship with the family who could act on behalf of the system (as a key worker, not a case manager) and repeatedly ask the 16 questions to ensure that issues are addressed on an ongoing basis. This could be one way in which we can think about how to manage and prioritise providing assistance to families with really complex needs.

61. Some families can spend all of their time going between services or not going to any services because the system is too complicated and intimidating. We need to drive some of the expertise currently tied up in tertiary services down into mainstream to make scarce specialist expertise more easily accessible and build the skills of mainstream service providers to meet the needs of vulnerable children and families within mainstream settings. For example, a mental health worker may be able to help a child care service understand how to better support a family rather than waiting until the problem has escalated enough for them to actually need to access the mental health service.

62. As well as driving expertise down into the mainstream, part of the solution is allowing the parent to choose what their priority is in terms of identified issues. One of the challenges with the PER is determining what to do if the parent identifies a whole range of issues as concerns. We are of the view that in those circumstances, the practitioner should ask the parent what would make the most difference to them and then respect their choice. We need to turn around the service system from telling parents what they need to instead asking parents what they need and providing a space for them where they can enter a single door and be provided with access to all of those services.

63. If practitioners had the capacity to act as a key worker on behalf of the system for complex families, they could help to manage that by liaising with the team (consisting of other services such as mental health, drug and alcohol and housing), who would all know the family but provide secondary consultations. We acknowledge that there are many challenges with that model too but for some complex families, it may be something to explore.

64. In summary, when designing an integrated service system it is important to consider place-based initiatives and to focus on the notion of working with and through the community as a major part of the strategy. The strategy should also include mapping of services that identify where and what those services are and resourcing local communities, most likely through local government, to identify how those services work together to a shared goal of reducing family violence.

65. We had a very positive experience using a community-partnering approach in supporting the roll-out of *Tasmanian Child and Family Centres* (**CFCs**) and better integrated child and family services in 12 disadvantaged communities. While the funding was provided by the Tasmanian Education Department, decisions about where the CFCs should be located, what they should look like, and what services they would provide were made in partnership with community members, using the Family Partnership Model to facilitate the process. This is an example of how to approach service and system design in a different way, starting with a long period of community consultation and discussion. Parents continue to have a major say in how the CFCs operate, and the CFCs also bring in services such as maternal and child health nurses and dental services, and those services become an integrated part of that system. The CFCs also employ community facilitators so that workers can go out into the community and find parents and families who need assistance.

66. One thing that the current system lacks is the capacity to find parents, engage them and bring them to a safe place where they can meet other parents, receive services and put down roots. This is important as what ultimately holds people in a place are other people.

Susan Annette West

Timothy Gerard Moore

Dated: 11 August 2015