Australian Government

Australian Institute of Family Studies

Family Violence Royal Commission

Submission from the Australian Institute of Family Studies

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Introduction

This submission is based on research conducted by the Australian Institute of Families Studies (AIFS) as part of its Violence and Families Research Program. It draws on a range of studies to highlight issues of relevance to the Royal Commission's terms of reference, including the prevalence, nature and persistence of family violence among separated families, analyses of responses to family violence in different parts of the family law system and some evidence in relation to prevention approaches in specific areas.[1]

AIFS has been commissioned by the Attorney-General's Department (AGD) to evaluate the impact of the amendments made to the *Family Law Act 1975* (Cth) that were designed to improve family law system responses to concerns about family violence and child abuse.[2] The final reports on this evaluation will be provided to the AGD on 31 August 2015. A further current project of relevance is an evaluation of an initiative involving a child protection practice leader being located in the Melbourne and Dandenong Registries of the family law courts to support interaction between the family law system and the child protection system. This evaluation, commissioned by the Victorian Department of Health and Human Services (DHHS), will be provided to the DHHS on 30 June 2015.

This submission draws on information from the following completed and published relevant reports:

- De Maio, J., Kaspiew, R., Smart, D., Dunstan, J., & Moore, S. (2013). *Survey of Recently Separated Parents: A study of parents who separated prior to the implementation of the Family Law Amendment (Family Violence and Other Measures) Act 2011*. Melbourne: Australian Institute of Family Studies (SRSP 2012 report);[3]

- Qu, L., Weston, R., Moloney, L. M., Kaspiew, R., & Dunstan, J. (2014). *Post-separation parenting, property and relationship dynamics after five years*. Melbourne: Australian Institute of Family Studies (Longitudinal Study of Separated Families [LSSF] Wave 3 report);[4]

- Kaspiew, R., Carson, R., Moore, S., De Maio, J., Deblaquiere, J., & Horsfall, B. (2014). *Independent Children's Lawyer Study: Final report*. 2nd edition. Melbourne: Australian Institute of Family Studies;

- Kaspiew, R., De Maio, J., Deblaquiere, J., & Horsfall, B. (2012). *Evaluation of a pilot of legally assisted and supported family dispute resolution in family violence cases*. Melbourne: Australian Institute of Family Studies;

- Campo, M., Kaspiew, R., Moore, S., & Tayton, S. (2014). *Children affected by domestic and family violence: A review of domestic and family violence prevention, early intervention and response services.* Melbourne: Australian Institute of Family Studies;[5] and

- Tayton, S., Kaspiew, R., Moore, S., & Campo. M. (2014). *Groups and communities at risk of domestic and family violence: A review and evaluation of domestic and family violence prevention and early intervention services focusing on at-risk groups and communities.* Melbourne: Australian Institute of Family Studies.[6]

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[1] The views expressed in this submission are those of the authors, not the Australian Institute of Family Studies, the Australian Government or the government departments (AGD and NSW Women) that funded the research referred to in the submissions.

[2] Information about this evaluation is available at: <www.aifs.gov.au/projects/evaluation-2012-family-violence-amendments>.

[3] This report was commissioned and funded by the AGD and provides benchmark data for the evaluation of the 2012 family violence reforms. The evaluation reports are due to be provided to the AGD on 30 August 2015. The SRSP 2012 is available at: <www.ag.gov.au/FamiliesAndMarriage/Families/FamilyLawSystem/Pages/Familylawpublications.aspx>.

[4] The first two waves of the LSSF were commissioned by the AGD and the then Department of Families, Housing, Community Services and Indigenous Affairs, now called the Department of Social Services (DSS), while AGD commissioned the third LSSF wave: <www.ag.gov.au/Publications/Pages/Post-SeparationParentingPropertyAndRelationshipDynamicsAfterFiveYears.aspx>.

[5] This report was commissioned and funded by Women NSW: <www.women.nsw.gov.au/violence_prevention/violence_prevention_studies>.

[6] This report was commissioned by Women NSW: <www.women.nsw.gov.au/violence_prevention/violence_prevention_studies>.

The SRSP 2012 report described the findings of a survey of 6,000 parents who separated in about 2011. These data provide benchmarking measures in relation to the impact of the amendments to the *Family Law Act 1975* (Cth), which were designed to improve responses to family violence and child safety concerns and came into effect substantively on 7 June 2012. A further study, the Survey of Recently Separated Parents 2014 (SRSP 2014)—which surveyed 6,000 separated parents two years after the reforms took effect—applied an identical methodology to support pre- and post-reform comparison of parents' experiences. Comparison of the findings of the 2012 and 2014 SRSP surveys is part of the Evaluation of the 2012 Family Violence Amendments. For a more detailed discussion of the SRSP methodologies, see Appendix A.

Family violence and separated families

The discussion in this section begins with a brief summary of the empirical evidence about the prevalence, intensity and persistence of family violence and safety concerns among separated parents. It then sets out the evidence about service use dynamics in the family law system and the shifts that have occurred since 2006. Finally, it provides insight into the challenges posed for the family law system in meeting the needs of complex families.

Prevalence, intensity and persistence

In the past five years, data from the LSSF and SRSP studies have examined the prevalence, nature and persistence of family violence and safety concerns[7] among separated parents to a much more detailed extent than has occurred previously.[8] These studies show consistent levels of these issues among two annual cohorts of separated parents, suggesting pre-separation violence is experienced by around 60% of parents (De Maio et al., 2013, Table 2.4) [9]. The LSSF Wave 1 data shows that just under 60% of parents reported a history of family violence before separation (this occurred between July 2006 and December 2007 for this group) (De Maio et al., 2013, Table 2.4). Similarly, SRSP 2012 demonstrates that 64% of the sample reported pre-separation violence. These parents separated in 2011. In both of these surveys, almost 20% of parents reported having safety concerns for themselves and/or their child as a result of ongoing contact with the other parent (De Maio et al., 2013, p. 38; Kaspiew et al., 2009, p. 28). It is important to appreciate however that these data cannot illuminate some of the complex issues surrounding the dynamics behind these experiences, including the extent to which the behaviour is defensive or aggressive in nature.

The SRSP 2012 established the variability of the experience of family violence through its analysis of the intensity with which various types of emotional abuse are reported, which showed that emotional abuse occurs across a continuum of severity (De Maio et al., 2013, p. 28–29). The analysis showed that across five possible ranges, 18% of parents fell into a low-intensity range and 13% into the two

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[7]   The safety concerns were for a parent and/or child as result of ongoing contact with the other parent.

[8]   Family violence is complex phenomenon. The discussion in this section is based on the measures used by AIFS in the LSSF (Wave 1 was reported in Kaspiew et al., 2009), and in the SRSP 2012 (De Maio et al., 2013). Measures that were common to both studies were questions about physical hurt and whether the former partners had: tried to prevent the participant from using the telephone or car, contacting family or friends; tried to prevent the participant from knowing about or having access to money; threatened to harm the participant, the child, themselves, other family or friends, pets; damaged or destroyed property; or insulted the participant with intent to shame, belittle or humiliate. In addition, the SRSP included a further question on whether there had been attempts to force unwanted sexual activity, as well as a number of questions about frequency of the behaviours (De Maio et al., 2013, p. 23). In LSSF Wave 3, the family violence measures concerning attempts to prevent access to money, cars and family and friends etc. were omitted, but three others were asked: attempted to force unwanted sexual activity; monitored whereabouts; and circulated defamatory comments with intent to shame, belittle and humiliate. It is important to recognise that the way these questions were asked has imposed some limitations in supporting understanding of the significant issues of gender dynamics and family violence. One important dimension that cannot be understood on the basis of these data is the dynamics of defence and aggression.

[9]   De Maio et al. (2013) applied a similar methodology, with a more detailed focus of family violence. Subtle differences in sample selection for the LSSF and SRSP 2012 resulted in slightly different sample profiles as far as parents who had never lived together were concerned. There were fewer of these in the SRSP 2012 sample, and this may account for the subtle differences in the incidence of family violence reported (De Maio et al., 2013, p. 12).

highest intensity ranges. Between 14% and 17% fell into two mid-range brackets. Gender differences were particularly evident in the two high-intensity score ranges, with women outnumbering men by more than three to one at the highest level and by almost two to one at the next highest level.

Figure 1 depicts the proportions of parents reporting different types of non-physical violence in the SRSP 2012. It demonstrates that 68% of mothers and 58% of fathers reported experiencing at least one of these types of emotional abuse before/during separation (De Maio et al., 2013, p. 24). Overall, a higher proportion of mothers reported experiencing most types of abuse than fathers, with the exception of behaviour designed to prevent contact with family or friends, where the proportion of affirmative responses were identical. Particularly marked differences—of 10 percentage points or more—are evident in relation to damaging and/or destroying property and attempting to force unwanted sexual activity (De Maio et al., 2013, p. 24).
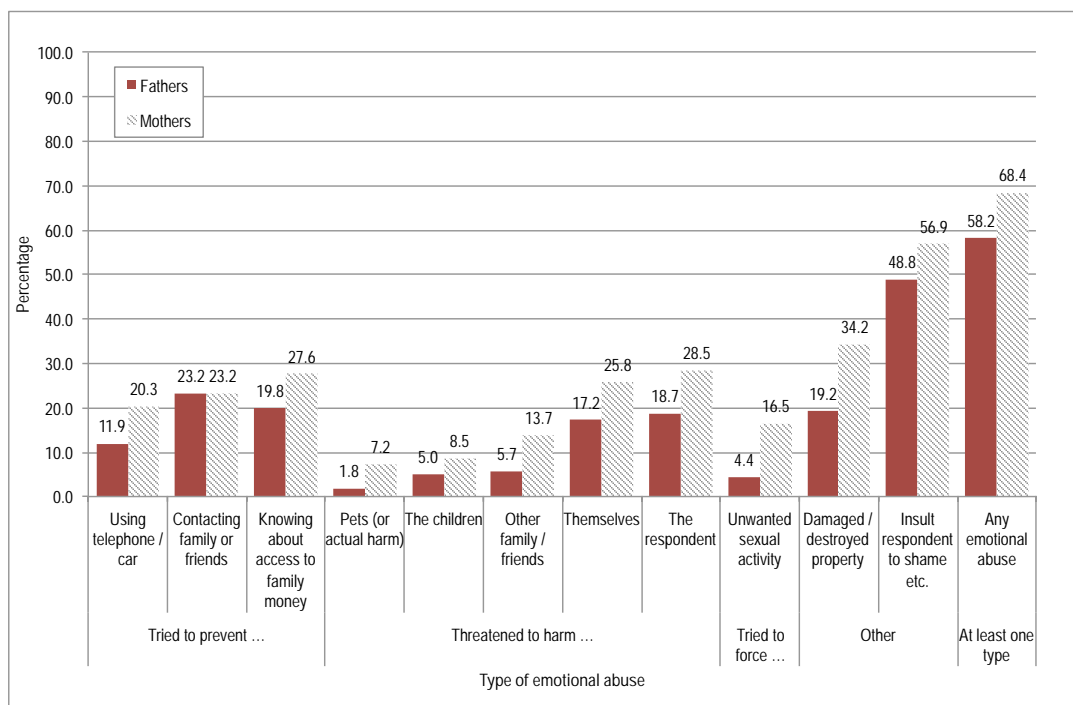
Notes: Data have been weighted. The "don't know" and "refused" responses were excluded from this analysis (less than 2% for each item). Percentages do not sum to 100.0% as multiple responses could be chosen.

Figure 1: Experiences of emotional abuse inflicted by focus parent *before/during* separation, father and mother reports

The extent to which family violence is sustained after separation is established by the findings from the third wave of the LSSF: 5–6 years after separation, 43% of mothers and 38% of fathers in LSSF Wave 3 reported experiencing emotional abuse in the preceding twelve months (Qu et al., 2014, p. 22).

In each of the three waves of the LSSF, between 15% and 18% of parents reported having safety concerns for themselves and/or their child as a result of ongoing contact with the other parent, and for about 5% these concerns persisted across the three waves (Qu et al., 2014, pp. 32-33). In SRSP 2012, 17% of parents reported having safety concerns for themselves and/or their child as a result of ongoing contact with the other parent (De Maio et al., 2013, pp. 38-39). The proportion of parents with safety concerns who reported attempting to limit the other parent's contact with the child was 49% in SRSP 2012 and between 39% (Wave 1) and 49% (Wave 2) in each of the three waves of the LSSF (De Maio et al., 2013, p. 38; Qu et al., 2014, pp. 32-33).

Substantial proportions of parents reported that their children witnessed the family violence. Focusing on reports of violence before or during separation, 53% of fathers and 64% mothers in SRSP 2012

reported that their children had seen or heard the violence (physical hurt or emotional abuse) (De Maio et al., 2013, p. 37). In relation to family violence experienced after separation, the findings show 43% of fathers and 50% of mothers in SRSP 2012 indicated their children had seen or heard the violence (De Maio et al., 2013, p. 37).

Family law system users

The past decade has seen significant shifts occur in the configuration and use of family law system services. In 2006, the federal government moved to support greater use of non-court-based mechanisms for resolving parenting disputes through the introduction of 65 Family Relationship Centres (FRCs) and the implementation of amendments to Part VII of the *Family Law Act 1975* (s 60I), which require parents to attempt family dispute resolution (FDR) prior to lodging a court application with exceptions.[10] As a result of this shift, the level of court filings in the three family law courts (the Family Court of Australia, the Federal Circuit Court of Australia and the Family Court of Western Australia) in 2012–13 reflects a 25% drop on pre-2006 levels in matters involving children (Kaspiew et al., 2015). This indicates that the expansion of the availability of FDR, the implementation of FRCs and the operation of s 60I have resulted in a shift of some of the caseload from courts to FDR in the years following the implementation of the 2006 family law reforms. Findings from the LSSF and SRSP 2012 studies show that increasing proportions of parents reported using FDR as the main pathway for resolving parenting arrangements. In a sample of parents who used family law system services prior to 2006, this was reported by 6%, compared with 7% in 2008 (Kaspiew et al., 2009, Table 4.1) and 10% in 2011 (De Maio et al., 2013, Table 4.8).

FDR is one of five parenting arrangement pathways examined in the LSSF and SRSP studies. These studies established that most parents resolve their matters through "discussions" between themselves (SRSP 2012: 69% of parents who had resolved their parenting arrangements, which was 74% of the total sample by the time of the survey, Table 4.8). A further 9% reported that their parenting arrangements "just happened". The proportions nominating the other three possibilities as their main pathway were: FDR 10%; a lawyer 7%; and the courts 3%.[11]

The evidence from the SRSP and LSSF Wave 3 demonstrate that the majority of separated parents resolve their parenting issues with little or no use of formal services. It is the parents at the more complex end of the spectrum who engage with services in the family law system. The use of FDR, lawyers and courts was most common among those who also reported a history of family violence and/or the presence of safety concerns, but this remains a minority of separated parents who use these services (De Maio et al., 2013, pp. 51–55; Qu et al., 2014, pp. 43, 44 and 59–65). The SRSP 2012 shows that of the parents who reported using FDR, lawyers and courts, those with a history of family violence were much more likely to report using formal services than those without such a history (De Maio et al., 2013, p. 51). For parents who did not report a history of family violence, resolution of parenting arrangements through discussions with the other parents was substantially more common than for parents who reported a history of family violence, with 80% of the former group reporting this, compared with 65% of parents who reported emotional abuse and 53% who reported physical violence (De Maio et al., 2013, Table 4.10).

These findings are important in that they also establish that substantial proportions of parents resolve parenting issues through discussions, even when there is a history of family violence. Nonetheless, the use of formal mechanisms, particularly lawyers and courts, was substantially more likely to be reported as the main resolution pathway by parents affected by family violence, particularly physical hurt. The courts were used by 8% of parents with a background of family violence involving physical

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[10] In theory, parents who can establish on reasonable grounds that there are concerns about family violence and child safety are not required to comply with this requirement (s 60I(9)(b)); however, the empirical evidence demonstrates that parents with these issues do use FDR and some reach agreements (eg., De Maio et al., 2013, p. 52).

[11] Higher proportions of the group still in the process of sorting out their arrangements nominated formal services as their main pathway: FDR 15%; a lawyer 15%; and the courts: 14%. Discussions were nominated by 43% and "just happened" by 11%.

hurt, compared with 4% of those with emotional abuse and less than 1% of those with no family violence. Lawyers were nominated as the main resolution pathway for 10% of the physical hurt group, 8% of the emotional abuse group and 3% of the no violence group.

Analysis of SRSP 2012 data that examines the parenting arrangements resolution pathways among parents who reported problems indicative of complexity in the survey shows differences in the extent to which parents with complex problems use different methods of resolving parenting issues. Parents were asked whether the following issues were present in their situation: problematic alcohol or drug use, mental ill health, gambling, problematic Internet or social media use, emotional abuse or safety concerns. The results of the analysis assessing the extent to which parents who reported these issues nominated particular pathways as "the main pathway" for resolving parenting arrangements shows the following notable findings (Kaspiew & Qu, 2014):

- of the parents who used court, 93% reported a history of emotional abuse, 41% reported a history of physical hurt, 44% had ongoing safety concerns for themselves and/or the child as a result of ongoing contact with the other parent, and 55% reported mental health issues;
- of the parents who used lawyers, 80% reported a history of emotional abuse, 28% reported a history of physical hurt, 24% had safety concerns, and 41% reported mental health issues; and
- of the parents who used FDR, 73% reported emotional abuse, 25% reported physical hurt, 18% had safety concerns and 41% reported mental health issues.

These data demonstrate that families with complex issues are dealt with across the system but are particularly concentrated in the court caseload. This is reinforced by the analysis assessing which pathways were used by parents reporting multiple problems used, which showed that parents with four or more problems were most likely to use courts (42%). In comparison, 23% of the group who used FDR and 29% of group who used lawyers had four or more problems. The mean number of problems among court users was 3.1, compared with 2.5 for lawyers, 2.2 for FDR, 1.8 for "just happened" and 1.5 for "discussions".

Families with complex issues: Insights from research on the practices of Independent Children's Lawyers

In 2012, AIFS was commissioned by AGD to conduct research on the role and efficacy of Independent Children's Lawyers (ICLs) in the family law system. The findings of the research demonstrated that these practitioners deal with the most complex children's matters in the family law system and that they play a very valuable role, particularly in gathering evidence and assuming an "honest broker" role in the adversarial settings in which family law children's matter are dealt with (Kaspiew et al., 2014). However, the research also demonstrated significant concerns among all family law system stakeholders about the quality of some ICLs and the extent to which their training and professional development equipped them to deal effectively with matters involving concerns about family violence and child safety. Since then, a number of developments have taken place as a result of legal aid commissions (including the Legal Aid Family Law Working Group) working with the family law courts and the family law section of the Law Council of Australia to address the issues arising out of the research. Thus, though the extent to which the following excerpt from the conclusion of the report reflects present day experiences may have changed, it nonetheless sheds light on some of the systemic issues faced by parents and children pursuing safe outcomes through the family law system.

Working with families at risk

The evidence shows that the ICL caseload is dominated by matters involving concerns about family violence and child abuse. It is also clear that ICLs can, when operating effectively, make significant contributions in these kinds of matters, particularly from a forensic perspective. However, the evidence shows a clear need for a stronger focus on equipping ICLs to operate in this context through initial training, accreditation and ongoing professional development processes. This need, acknowledged by ICLs themselves and other stakeholders, is strongly illustrated in the disparity in

responses between ICLs and judicial officers in questions seeking assessments in relation to ICLs' ability to work with parents and children/young people at risk of harm. In relation to the ability to detect and respond to safety issues for children and young people, positive assessments of efficacy (good or excellent) were made by 69% of ICLs and 76% of judges (Kaspiew et al., 2014, Table 7.3). In relation to detecting and responding to safety issues for parents, the disparity was considerably wider, with 56% of ICLs nominating their ability as good or excellent, compared with 72% of judicial officers (Kaspiew et al., 2014, Table 7.3).

Systemic ability to deal with complex cases

A broader issue raised by the findings of this research concerns the system's ability to deal with complex cases, which almost always involve concerns about family violence and/or child abuse. The AIFS *Evaluation of the 2006 Family Law Reforms* highlighted the fact that cases involving these issues were taking longer and using more services to resolve matters (Kaspiew et al., 2009, p. 232). The data from parents and children/young people in the ICL study is consistent with this point and provides some indication of the effects that this can have at a personal level, with 2–5 years of children's/young people's lives being spent engaging with legal processes, and in some instances with multiple professionals associated with child protection, police and family law processes. In some cases, during this time, the children were clearly in unsafe and inappropriate parenting arrangements, as eventually shown by the outcome of the family law proceedings.

Some of the parents interviewed described circumstances in which inept approaches on the part of professionals, including ICLs, contributed to prolonging the resolution of the matter.

Families with complex issues: Promising practice approaches

In light of the findings about the level of complexity demonstrated by family law system clients described earlier, and the conclusion cited from the ICL report, it is pertinent to draw attention to some features of a practice model developed to provide family dispute resolution for families affected by a history of family violence. The Coordinated Family Dispute Resolution (CFDR) model was developed by Brisbane Women's Legal Service and piloted in five locations across Australia between the final quarter of 2010 and the beginning of 2012. It was a multi-disciplinary, multi-agency working model predicated on the provision of case management, legal advice for each party and access to support from a specialised family violence support professional (SFVSP) for women, and men's support professional (MSP) for men. AGD funded the pilot and the evaluation. The model applied a "predominant aggressor" approach to assessing the nature of the family violence dynamics in each family (Kaspiew et al., 2012). Although the evaluation conducted by AIFS indicated a very limited number of matters proceeded to FDR (27 out of 126), the evaluation highlighted several particular strengths of the approach (Kaspiew et al., 2012). These included the provision of case management and the application of ongoing risk assessment for families where the evaluation findings demonstrated that risks could escalate and abate throughout the process. Risk management was led by the SFVSP and supported by the other professionals. The evaluation found that these features contributed to the provision of a holistic response to the families involved in the pilot. The following excerpts from the conclusion to the evaluation report highlight the challenges and advantages of collaborative practice and risk management in this context.

What challenges and advantages arise from the interdisciplinary nature of the model?

The quality of the collaborative relationships between the professionals and agencies working in the CFDR pilot is integral to determining whether or not it operates effectively. Establishing effective collaborations in the partnership is a significantly time- and resource-intensive exercise. It also adds to the logistic complexity of the CFDR process because of the need to coordinate client contact with multiple professionals and case-management and other communication activities between multiple professionals.

The partnership constellation in one location changed because of a number of issues between the partners that could not be resolved. The evaluation evidence indicates that the quality of the service to clients was compromised because of these tensions. In other locations, tensions of varying levels of significance (some quite minor) and over varying issues were also evident, but these did not become so significant as to compromise the overall functioning of the partnership and were resolved through discussion. An issue that arose in several locations related to approaches to family violence and to the application of different philosophical constructions, in some cases underpinning different clinical decisions. In a further location, discussions over the application of child-inclusive practice continued throughout the evaluation period.

The advantages of multi-disciplinary practice include the capacity to provide a more holistic and comprehensive service to clients. Clinical decisions are the shared responsibility of the professionals in the team, with insights from the SFVP, MSP and the case manager/FDR practitioner feeding into decisions about case progress. Access to legal advice also strengthened the service provided to clients by providing them with information about their legal position.

The area of information sharing as an aspect of collaborative practice was complex, particularly in relation to what information could be shared by and with lawyers. Different approaches were adopted in various locations, but the practice of lawyers routinely obtaining consent to share information, which applied in one location, would seem to have particular strengths. A further practice related to information sharing, and concerned with client management and collaborative practice more generally, was having SFVPs and MSPs attending legal advice appointments with clients. Where this happened, the teamwork approach appeared to strengthen the program's ability to manage client expectations in the CFDR process.

More generally, many professionals working in the CFDR pilot indicated that the experience of working in the pilot had strengthened their understanding of the way the other practitioners operate. Many also indicated it had improved their ability to work collaboratively.

Is the safety of children, parents and professionals adequately maintained in the pilot program process?

It is clear that an intensive focus on risk assessment and risk management is applied throughout the CFDR process. An active process of risk management takes place as risks escalate and abate as the matter proceeds through its various steps. Safety planning is an important part of the work that support professionals undertake with clients, but it was not clear whether adequate safety planning occurred in all instances (for example, some predominant victims interviewed reported not having developed a safety plan). Different approaches to risk assessment were applied in different locations and pilot services.

SFVPs and MSPs play particularly important roles in risk assessment and management. There were some case examples that provided evidence of both SFVP and MSPs actively assisting clients to manage their emotional states as the process progressed. This is intensive and challenging work. However, the evidence of more intensive support being provided to predominant victims reinforces the known challenges of engaging men in the use of support services, evident throughout the relationship support sector generally, but especially where there has been a history of family violence.

Some evaluation evidence highlighted the area of risk assessment and management as a field where different philosophies and approaches could create tensions and conflict within the partnership. In most instances these were effectively managed and resolved. However, there is also evidence that some clients felt emotionally unsafe (and in one instance physically unsafe) in FDR sessions. The potential for such proceedings in standard FDR or CFDR to trigger emotional trauma should not be underestimated. It is clear that processes around risk assessment and management and making clinical judgments about the conduct of FDR are areas in which particular challenges arise in multi-disciplinary, multi-agency practice. Where practitioners work effectively as a clinical team, CFDR practice has the potential to reduce the possibility that clients will placed in unsafe and traumatic

situations. Moreover, it is also evident that more experienced professionals felt greater levels of confidence in their own capacity to deal with family violence.

Summary

The discussion in this part of the submission has drawn on a number of different empirical studies to highlight what is known about the characteristics of separated families, family violence and family law system responses to them. Importantly, however, an extensive evaluation of the impact of the 2012 family violence amendments is currently being completed and will be provided to AGD on 31 August 2015. Two studies focusing on two different annual cohorts of separated parents (LSSF Wave 3 and SRSP 2012) have shown that family violence (emotional abuse and physical hurt) is more common than not among separated families and that up to one in five have concerns for the safety of themselves and/or their children as result of ongoing contact with the other parent after separation. The experience of family violence is variable in nature, with a continuum of severity and frequency evident among the SRSP 2012 population. Findings from the LSSF Wave 3 report show that emotional abuse is sustained for five years after separation for a sizeable minority of parents. Over the longer term, safety concerns dissipated for some parents, arose newly for others and were sustained over five years for close to five per cent of the 2008 cohort.

In the nine years since the implementation of the 2006 family law system reforms—which sought to encourage greater use of relationship services rather the courts for the resolution of parenting arrangements post-separation—court filings have declined by 25% on pre-2006 levels and the use of FDR has risen incrementally. It is clear that complex families affected by family violence and safety concerns, and other problems (including mental ill health and substance misuse) are common in the client bases of FDR services, lawyers and courts, but are particularly concentrated in the family law courts.

In the context of the adversarial way in which parenting matters are dealt with when they are litigated in the family law courts, ICLs potentially play an important role in placing the focus on issues of risk and risk management. The findings of the ICL study, however, indicate that ICL capacity in this regard requires further support through training and professional development. The findings of the ICL study also highlighted the implications for children and parents of being involved in complex family law matters, where litigation can extend over years to the detriment of timely, safe outcomes for children.

The approach adopted in the CFDR model, in which case management, ongoing risk management, legal advice and support, were available for the parents whose matters were dealt with in the model represents an approach tailored to meet the needs of families who are negotiating parenting arrangements against a background of family violence. Though the CFDR evaluation highlighted some significant complexities in the implementation of this approach, it also found strengths in the coordinated approach represented in the model.

Prevention approaches

The AIFS report on children exposed to family and domestic violence

Effects of domestic and family violence on children

The 2014 AIFS review of children exposed to domestic and family violence (DFV) examined a wide range of research analysing the effects of DFV on children. The report found that children exposed to DFV in the home may suffer a extensive array of poor developmental, behavioural and health/mental health outcomes, including poorer academic outcomes, learning difficulties, higher rates of school absenteeism, poorer mental health and wellbeing, externalising and internalising behaviours, depression, anxiety, low self-esteem and aggression (Heugten & Wilson, 2008; Holt, Buckley, & Whelan, 2008; Klitzman, Gaylord, Holt, & Kenny, 2003; Lundy & Grossman, 2005; Schnurr &

Lohman, 2013). Children exposed to DFV may also experience complex trauma symptoms, including post-traumatic stress disorder (PTSD), resulting in psychosocial and sometimes physical responses. The impact of complex trauma is thought to have longlasting detrimental developmental effects on children, and into adulthood (Jaffe et al., 2012), including the ability to form healthy relationships and attachments.

Children exposed to DFV are also more at risk of experiencing abuse, including sexual abuse (Bromfield, Lamont, Parker, & Horsfall, 2010; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008).

Intergenerational transmission of violence

Longitudinal, meta-analytic and population-based studies have consistently linked childhood exposure to DFV with future perpetration or future victimisation. There is, however, some debate on the question of whether exposure to DFV alone is a factor in future perpetration of violence. Participants in studies where a correlation is established experience childhoods characterised by several risk factors (such as socio-economic disadvantage, parental mental ill health, parental substance abuse and child abuse) and "confounding psychosocial" contexts (Fergusson, Boden, & Horwood, 2006 p. 103; Higgins, 2004; Temple, Shorey, Tortolero, Wolfe, & Stuart, 2013; Fulu et al., 2013). Moreover, gender roles and gender stereotypes and violence-supportive attitudes are important for understanding the correlation (Fulu et al., 2013; Temple et al., 2013).

Response

There is relatively little literature that considers the most effective responses to children who have been exposed to violence. Some of the strongest evidence available on responding to children exposed to violence focused on therapeutic interventions that address both caregivers (mostly mothers) and children, in order to repair the potentially damaged parental relationship following experiences of DFV (Bunston, 2008; Bunston & Heynatz, 2006; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Humphreys, 2011; Humphreys, Thiara, & Skamballis, 2011; Lieberman, Ippen, & Van Horn, 2006). Approaches that are trauma-informed and culturally/religiously appropriate are also important, as is effective collaboration between adult and child services. In a literature review for the Scottish Government, Humphreys and Houghton (2008) provided an extensive overview of the literature on best practice response for children, and outlined key directions for good practice provision. These include:

- removing reporting to child protection as a first instance response to children exposed to DFV;
- improving links and collaboration between adult's and children's services;
- developing therapeutic programs that address the mother and child bond;
- providing therapeutic responses that offer both individual counselling and group work; and
- improving the ability of health workers, teachers and other social service professionals to screen for, identify and respond to DFV (Humphreys & Houghton, 2008).

The AIFS review found that there were significant barriers to providing adequate response services to children, such as services having limited resources and capacity to evaluate programs, limited qualified staff to meet the demand for services (particularly for therapeutic services), and impermanent funding arrangements.

Prevention

As a field of knowledge and practice in Australia, DFV primary prevention is in its early phases. Australian developments in this area have been strongly influenced by international approaches, particularly the World Health Organization (WHO) public health model with its (socio-ecological) approach, which focuses on preventing DFV before it occurs through the delivery of universal and targeted strategies across the life span and in various community contexts. The underpinning theory of

causation in this framework is that DFV is a direct result of gender inequality, traditional gender roles and the interplay between factors at four levels of influence: individual, relationship/family, community and wider society (Fulu, Kerr-Wilson, & Lang, 2014; WHO, 2010). However, there is general agreement in the literature that there is a paucity of evidence for "what works" in primary prevention, and thus the socio-ecological model of primary prevention is largely theory-driven. As such, primary prevention strategies are generally based on what is known about perpetration. The literature concerning factors associated with perpetration strongly point to DFV as being linked with traditional/normative beliefs about gender, attitudes supportive of violence, and socio-economic factors such as low education, substance abuse and a childhood history of trauma or DFV.

School-based primary prevention programs that address the underlying cause of DFV are endorsed in the literature and recommended through international and national policy frameworks (Council of Australian Governments [COAG], 2009; Fulu et al., 2014; VicHealth, 2007; Whitaker, Murphy, Eckhardt, Hodges, & Cowart, 2013; WHO, 2010). However, there are very few evaluated programs for children aged under 8 years in Australia, as most evaluated programs are delivered to secondary school students. The evidence is only slowly emerging. However, areas where prevention strategies targeting children and families have been shown to be effective include:

■ school-based respectful relationship programs (Fulu et al., 2014; Whitaker et al., 2013);

■ programs targeting new parents (Flynn, 2011; Fulu et al., 2014);

■ programs targeting men and boys (Carmody, Salter, Presturudstuen, Ovenden, & Hudson, 2014); and

■ home visiting programs for at-risk families (Bair-Merrit et al., 2010).

The AIFS report on groups and communities at risk of domestic violence

Background

This report set out the findings of research into DFV prevention initiatives focused on groups and communities identified as being at greater risk of experiencing DFV and/or having difficulty accessing support services. This research was commissioned and funded by the NSW Department of Family and Community Services. It contributed to the development of the knowledge base on DFV prevention strategies and the needs of at-risk groups and communities, and aimed to support the implementation of aspects of the National Plan to Reduce Violence Against Women and Their Children (COAG, 2009) and the NSW Government's (2013) It Stops Here: Standing Together to End Domestic and Family Violence strategy.

Effects of DFV on at-risk groups and communities

Groups identified as being at greater risk of experiencing DFV compared with the general community include Aboriginal and Torres Strait Islander women; women from culturally and linguistically diverse (CALD) communities; people who identify as gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ); young women; and women in regional, rural and remote (non-urban) communities. There is a high level of diversity between, and within, these at-risk groups and communities. Consequently, there is significant variation in the contexts in which DFV occurs, as well as its effects. While it is established that these groups are at higher risk of experiencing DFV than the general community and/or are less likely to access support services, the evidence base on the effects of DFV in relation to each of these at-risk groups and communities is variable. Better evidence is required across the board, but empirical understandings are particularly underdeveloped in relation to the extent and effects of DFV on CALD women; people who identify as GLBTIQ; women with disabilities; and women from regional, rural and remote communities. There is more evidence regarding the effects of DFV on Aboriginal and Torres Strait Islander women and younger women than the other groups and communities; however, there are gaps in this evidence as well. **There is a need to invest in building the evidence base through rigorous research and evaluation, including supporting research that**

is coordinated, is focused on collecting data that can be compared with other research, and is sensitive and responsive to the particular needs of at-risk groups and communities.

Primary prevention

In order to support effective DFV prevention and early intervention practice, better evidence about the effectiveness of initiatives is needed. Only one approach—school-based healthy relationship programs—has been established to be effective (WHO, 2010). Aside from this one example, there are significant gaps in the evidence in relation to "what works" with the various at-risk groups and communities. Our research demonstrated that there is a significant amount of practice knowledge within the DFV service sector. However, there is relatively little formal evidence about the effectiveness of prevention and early intervention activities that focus on at-risk groups and communities. There is consensus from the literature and our stakeholder consultations that a concerted effort to develop the evidence base about what is effective in DFV prevention and early intervention is required.

Our research focused on prevention and early intervention programs that were aimed at women in at-risk groups and communities. The evidence regarding the effectiveness of DFV prevention programs that empower and educate women is still emerging, but it is promising (WHO, 2010). Prevention and early intervention initiatives aimed at women are not a comprehensive response to DFV. They need to be delivered in conjunction with initiatives aimed at perpetrators. DFV is a complex and multifaceted problem that needs to be addressed at multiple levels. It is clear that men's violence against women is critically linked to historically unequal power relationships between men and women (Wall, 2014). Given this, empowerment and education programs aimed at women that address this inequality are a necessary component of attempts to ensure that women and children live free from violence (WHO, 2010).

Our service scoping and stakeholder consultations indicated that there are gaps in prevention and early programs for all at-risk groups and communities. These gaps are more marked in relation to some communities than others. There is a particular dearth of services for people who identify as GLBTIQ; regional, rural and remote women; and women with disabilities and mental ill health. In some geographical areas, the lack of services that address the specific needs of people from these communities is stark. Other at-risk groups, such as CALD and Aboriginal women, have more prevention and early intervention programs aimed at them. However, this does not mean that there are no gaps, and in some instances there are questions about the capacity of some services to cope with the diversity within these communities. Questions of community acceptability of, and access to, programs are relevant for all at-risk groups and communities.

Other key findings in relation to DFV prevention and early intervention initiatives are:

- Both universal and targeted prevention and early intervention approaches are needed.
- There is a need for large-scale, population-wide prevention messages, but such messages need to be relevant for communities that are identified as being at high risk of DFV. Large-scale public health campaigns aimed at preventing DFV cannot run in isolation; they need to be delivered in conjunction with community-based initiatives so that the initiatives work across multiple levels in the community. A combination of these forms and levels of DFV prevention activity is understood to have the most promise in addressing DFV.
- DFV prevention and early intervention initiatives aimed at at-risk groups and communities need to be community-driven.
- While at-risk groups and communities should be able to access all DFV services and have their needs met, there is also a need for prevention and early intervention initiatives to be community-driven. Each of the at-risk groups has specific sets of issues and needs, giving rise to different best practice approaches. Generic approaches are often inappropriate. Organisations that are enmeshed within communities, have established relationships of trust, and can engage effectively with

members of their community are often best placed to deliver DFV prevention and early intervention initiatives.

- DFV prevention and early intervention initiatives need to be delivered in the context of a clear and coherent policy framework

- Over the last 20 years or so, there has been a move in many jurisdictions to an integrated policy and practice approach to complex social issues such as DFV. Throughout Australia, there are differing levels of integration of approaches to the issue of DFV and related service provision. **Our research indicated that the development of a clear and coherent policy framework better enables discrete service sectors to work towards common goals, and help to ensure the needs of at-risk groups and communities are met across the various sectors.**

- Funding needs to be long term and sustainable.

- The disadvantages that arise from short-term and ad hoc funding pools was a significant theme in the literature and consultations. This is an issue of general relevance in the DFV area but has particularly acute implications for the groups considered in this report. In light of the need for initiatives to be community-driven, short-term and fragmented funding approaches mean that the knowledge, trust and expertise that are developed when a program is developed are dissipated when it is discontinued. This stands in the way of the development of sustained and coherent approaches that will support long-term change. **It is clear from this research that funding arrangements need to be longer term and better coordinated to enable the DFV sector to provide high-quality services and build on expertise.**

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Appendix A
Additional resources

In addition to the resources referred to in this submission, we draw your attention to the following resources that are available on the AIFS website or in links from it:

Family law
http://www.aifs.gov.au/familylawviolence/
Hayes, A., & Higgins, D. (Eds.) (2014). *Families, policy and the law: Selected essays on contemporary issues for Australia*. Melbourne: Australian Institute of Family Studies. [308 pp]. Available at: http://www.aifs.gov.au/institute/pubs/fpl/index.html
http://www.aifs.gov.au/institute/pubs/fpl/index.html

Family law & Child Protection
The evaluation of Magellan - which focused heavily on interagency communication and coordination, across state/commonwealth boundaries - can be accessed from here:
http://www.aifs.gov.au/institute/pubs/magellan/index.html
Higgins, D. J., & Kaspiew, R. (2008). 'Mind the gap…': Protecting children in family law cases. *Australian Journal of Family Law, 22(3), 235-258.*
Higgins, D. J. (2010). "Sex, Lies and Videotapes": Gathering and assessing evidence of child abuse in family law cases. *Psychiatry, Psychology and Law, 17(3)*, 398-411.
Higgins, D. J., & Kaspiew, R. (2011). *Child protection and family law… Joining the dots* (NCPC Issues 34). Melbourne: National Child Protection Clearinghouse at the Australian Institute of Family Studies. Retrieved from
<https://www3.aifs.gov.au/cfca/publications/child-protection-and-family-law…-joining-dots>

Multi-type maltreatment
Below are a number of articles on the overlap between children's exposure to family violence and other forms of child maltreatment:
Higgins, D. J. (2004). Differentiating between child maltreatment experiences. *Family Matters, 69,* 50-55. Online: <http://www.aifs.gov.au/institute/pubs/fm2004/fm69/dh.pdf>
Price-Robertson, R., Higgins, D., & Vasallo, S. (2013). Multi-type maltreatment and polyvictimisation: A comparison of two research frameworks. *Family Matters, 93*, 84-98. Melbourne: Australian Institute of Family Studies. Available: <http://www.aifs.gov.au/institute/pubs/fm2013/fm93/fm93h.html>
Price-Robertson, R., Rush, P., Wall, L., & Higgins, D. (2013). Rarely an isolated incident: Acknowledging the interrelatedness of child maltreatment, victimization and trauma. *CFCA Information Exchange*. Melbourne: Australian Institute of Family Studies. Available: <http://www.aifs.gov.au/cfca/pubs/papers/a144788/index.html>

Value of public awareness campaigns:
Are social marketing campaigns effective in preventing child abuse and neglect? Briony Horsfall, Leah Bromfield and Myfanwy McDonald. NCPC Issues No. 32 — October 2010
See: https://www3.aifs.gov.au/cfca/publications/are-social-marketing-campaigns-effective-preventing-child

Value of other prevention programs:
Holzer, P. J., Higgins, J., Bromfield, L. M., Richardson, N., & **Higgins, D. J.** (2006). *The effectiveness of parent education and home visiting child maltreatment prevention programs*. (Child Abuse Prevention Issues No. 24). Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies.
Available at: http://www.aifs.gov.au/nch/pubs/issues/issues24/issues24.html
Service delivery coordination - best practice:

Stewart, J., Lohoar, S., & Higgins, D. J. (2011). Effective practices for service delivery coordination in Indigenous communities. *Closing the Gap Clearinghouse Resource Sheet No. 8.* Canberra: Closing the Gap Clearinghouse, Australian Institute of Health and Welfare / Australian Institute of Family Studies. Retrieved from:
http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2011/ctgc-rs-08.pdf

Primary prevention in sexual violence:
http://www.aifs.gov.au/acssa/resources/primaryprevention.html

Preventing child sexual abuse:
This report has been provided to the Department of Social Services, as part of funded work under the *National Framework for Protecting Australia's Children*. It will soon be released publicly.
Quadara, A., Nagy, V., Higgins, D., & Siegel, N. (2014). *Conceptualising the prevention of child sexual abuse. Final Report*. Melbourne: AIFS.

Public health approaches
Also attached to this submission (see separate document at Attachment A) is a ***draft*** manuscript – that is currently under review - which explains the public health approach to prevention of child maltreatment (which I would argue sits alongside and overlaps in part with family violence prevention).

Higgins, D. J. (submitted). A public health approach to enhancing safe and supportive family environments for children. *Family Matters, 96.*

Appendix B

This submission refers to datasets from two studies conducted by AIFS that are relevant to some of the terms of references for the current Inquiry into Child Support. These are the LSSF, which entails three survey waves covering a five-year period after separation, and the SRSP 2012, a single-wave study. The first two waves of the LSSF were commissioned by the AGD and the then Department of Families, Housing, Community Services and Indigenous Affairs, (now the Department of Social Services), while AGD commissioned the third LSSF wave and the SRSP 2012.

The parents in these studies were recruited for interview when they had been separated for a relatively short period of time (described below). The samples were derived from the same administrative dataset, though in different years, now managed by the Department of Human Services—Child Support (DHS–CS).[12] While we believe that the vast majority of separated parents with a child under 18 years are represented in this administrative dataset, some parents do not register with DHS–CS. To that extent, the analysis cannot claim to be one based on a random sample of all separated parents with a child under 18 years of age.

The Longitudinal Study of Separated Families

The LSSF is a national study of parents with a child under 18 years of age who had separated after the 2006 reforms were introduced and who were registered with the DHS–CS in 2007 and were still separated at the time of the survey. Parents with child support arrangements that involved mothers having the liability to pay fathers were over-sampled. Findings based on the first two waves formed components of the AIFS evaluation of the 2006 reforms to the family law system (see Kaspiew et al., 2009; Qu & Weston, 2010). In all three waves, almost all child-related questions asked of parents (e.g., care-time arrangements) focused on one child born of the separated relationship.

Some 10,000 parents participated in the first survey wave (4,983 fathers and 5,019 mothers). Interviews were conducted in late 2008, on average 15 months after separation, though it should be noted that 11% of respondents had never lived together or had separated before the study child was born.[13] The second wave of data collection was conducted between September and October 2009, with 70% of the original parents being interviewed again. Even though only 12 months had elapsed between the first two survey waves, the study highlighted considerable changes in the families' circumstances. For instance, around one in three of the children experienced different care-time arrangements (Qu & Weston, 2010).[14] The third wave of data collection took place between September and November 2012, with 9,028 parents interviewed (comprising 5,755 members of the original sample and a "top-up" sample of 3,273 parents). Both the original and top-up sample members had been separated for an average of five years at the time of this survey wave.

In Wave 1, 41% of the children were 0–2 years old and 18% were 4–5 years old.[15] That is, nearly 60% of these children were under 5 years old. By Wave 3, two-thirds of these "study children" were 5–11 years old (i.e., of primary school age).

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[12] When the LSSF Wave 1 sample was derived, this dataset was managed by the then Child Support Agency.

[13] The weighted data (adjusted for the differential tendency of separated parents with different characteristics to participate in the survey) suggest that 13% of parents had never lived together or had separated before the child was born. Apart from the small proportion who had never lived together, the parents had separated between July 2006 and September 2008, with all except 4% of these parents having separated between July 2006 and December 2007.

[14] Any observed proportion of children experiencing a change in care-time would be a function of the nature of the categories of care time adopted in this analysis. In the LSSF, care-time arrangements were split into nine categories, some of which covered a broader time frame than others. For example, one category entailed the child spending near equal number of nights with each parent (48–52% of nights), while another entailed the child spending 66–99% of nights with the mother and 1–34% of nights with the father.

[15] For some children, both parents participated in the study. Where this was the case, only one parent's report was randomly selected, to avoid "double counting". The percentages referred to in this paragraph were based on the weighted data (adjusting for the differential tendency of separated parents with certain characteristics to participate in the survey). Before these weights were applied, 35% of children were 0–2 years and 17% were 4–5 years.

The Survey of Recently Separated Parents 2012

The SRSP 2012 is a national study of the experiences of 6,119 parents with a child under 18 years old who had separated between 31 July 2010 and 31 December 2011, had registered with the DHS–CS during 2011, and were still separated at the time of the survey. The research was commissioned and funded by the AGD and examined parents' experiences of, and system responses to, family violence and child safety concerns.

The survey took place between August and September 2012 and focused on parents whose main use of family law system services occurred in approximately 2011, prior to the reforms introduced by the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth). The sample of parents had been separated for an average of 17 months. As was the case with the LSSF, one child born to the separated couples was focused on for the majority of the child-related questions in the SRSP 2012. These children were most commonly aged 5–11 years (39%), with 21% of children aged in the 0–2 years and 17% aged 3–4 years.

Australian Government

Australian Institute of Family Studies

Family Violence Royal Commission

Submission from the Australian Institute of Family Studies

Attachment A

A public health approach to enhancing safe and supportive family environments for children

Daryl J. Higgins

Families are the mainstay of safety and support for children's positive development (Bowes, Watson, & Pearson, 2009). Although families can be the source of harm (e.g., from child abuse, neglect or exposure to domestic violence), they can also be the most important source of protection from harm for children when they provide a sense of security, foster self-esteem and respond appropriately to children's needs.

Although most children live in safe and supportive environments, governments in Western, Anglophone countries are aware that too many children are becoming known to statutory child protection services. This has led to a shift in thinking, away from solely concentrating on the actions of "tertiary systems" (which respond to concerns about high-risk families) towards a broader public health approach to protecting all children (Bromfield, Arney, & Higgins, 2014). Rather than focusing on the primary or more severe manifestations of the problem, scholars and policy-makers have sought to adopt a broader public health approach to the safety and protection of all

children (Child Family Community Australia [CFCA], 2014). The basic tenet of a public health approach is that the problem of child maltreatment (and its antecedent risk factors) exists on a continuum of severity, and that strategies can be put in place to shift the risk profile of the entire population, resulting in a reduced likelihood of children coming to the attention of statutory authorities (Higgins & Katz, 2008; O'Donnell, Scott, & Stanley, 2008; Scott, 2006).

Researchers in the child maltreatment field have focused their attention—and rightly so— on "problematic families". Not only are more children becoming known to child protection services, but also the range of problems and issues faced by these children and their families extends beyond the most extreme forms of abuse and neglect to encompass broader social problems and family dysfunction (Bromfield, Lamont, Parker, Horsfall, 2010). In particular, researchers and policy-makers have focused attention on the risk factors that statutory child protection services see as the typical "drivers

> Parenting is a challenge for many people— not just those who come to the attention of statutory services.

of demand" for statutory services. Reviews of family law, child protection services and the juvenile justice system reveal a common set of family problems that typically lead to engagement with these service systems—that is, family violence, parental mental illness and addictions to alcohol, other drugs and gambling (Higgins & Katz, 2008). The common feature of such parental behaviours or circumstances is that they can impair a family's capacity to provide positive parenting and ensure that children are safe and protected from harm.

Although researchers know a lot about the familial risk factors for child maltreatment (e.g., see CFCA, 2013), less is known about the precursors to some of those risk factors, and whether family environments that are more or less problematic can be identified in the general population.

Examining indicators of the wellbeing of children who are growing up in a range of different family environments can increase understanding of how services may be provided to improve family environments more broadly in society, and achieve more than can be achieved through statutory child protection services or through targeted programs to families of children identified through welfare services.

Child protection: Public scourge or public health issue?

In relation to the protection of children, many child welfare advocates and researchers have for over two decades recognised the value of a public health approach—and the language of public health is used in many policy documents

and strategies internationally. However, Australia—along with similar countries such as the UK, the USA, Canada and New Zealand— still struggles under the weight of unsustainably high levels of notifications of child protection concerns.

Although there is debate about whether the underlying incidence of maltreatment has changed, there is no doubt that over the past two-and-a-half decades, there has been a very large increase in notifications to statutory child protection authorities (see Table 1). In line with this increase in notifications, there has also been a substantial increase in the number of children living in out-of-home care.[1] As shown in Table 1, the number of children in out-of-home care has risen in absolute terms, as well as when expressed as a rate per 1,000 children in the population (from 3.0 in 1990 to 8.1 in 2014).

In the past 3–4 years, there have been some indications of a slowdown in the rate at which notifications have been rising; however, the number of children living in out-of-home care— which is a more accurate measure of severe cases of maltreatment or high-level risks in that children cannot remain safely in the care of parents—has continued to climb steeply.

Given the continued high demand on statutory child protection services, is the problem that the "public health approach" per se doesn't work, or is it that the strategies being operationalised on the ground are not truly consistent with the stated approach? One could ask: Where are the features of true population-level prevention strategies, as demonstrated in strategies to address road safety or tobacco use?

Key features of successful public health strategies include: public awareness campaigns (implemented in settings such as schools, community organisations, workplaces and the media) with messages that target not only the individual but also broader social attitudes; provision of programs to improve relevant skills; regular surveillance and strict enforcement of prescribed behaviours; and making improvements in environmental circumstances affecting the behaviours and its context. (For further information on public health initiatives and their success, see Ward & Warren, 2007.)

In the public eye, child maltreatment is often seen as being the problem of negligent, undeserving parents, or in the case of sexual abuse, perpetrated by "dirty old men". It is not seen as being a series of behaviours that occur along a continuum of severity (and frequency), or that broader social attitudes play a role

Table 1: Trends in child protection notifications and children living in out-of-home care in Australia: 1989–90 to 2013–14

Year	Total population of children in Australia (0–17 years)	Notifications to statutory child protection authority [a]		Children living in out-of-home care at 30 June	
		Number	Rate per 1,000 [b]	Number	Rate per 1,000
1989–90	4,188,795	42,695 [c]	10.2	12,406	3.0
1999–2000	4,766,920	107,134	22.5	16,923	3.6
2009–10	5,092,806	286,437	56.2	35,895	7.0
2013–14	5,286,000 [d]	304,097	57.5	43,009	8.1

Notes: [a] "Notifications" refers to the total number of reports received by child protection departments about children in need of protection, not to the number of unique children about whom there might have been multiple concerns notified during the financial year. [b] As the number of notifications may include multiple notifications relating to the same child, the rate should be interpreted with caution. [c] The number of notifications for 1989–90 excludes Tasmania and ACT, for whom data were not available. Therefore comparing the number and rate with other years should be interpreted with caution. [d] This is a preliminary population estimate—subject to revision in future release of this ABS Catalogue.

Sources: Australian Bureau of Statistics (2010; 2014); Australian Institute of Health and Welfare (AIHW; 2001, 2011); Productivity Commission (2015; Tables 15A.5 & 15A.18); WELSTAT (1991). Updated from Higgins (2011).

in creating or condoning situations in which child abuse is more likely to occur. I think it is fair to claim that society largely sees it as a dichotomy: there are abusive families—and then there are the rest of us.

Do families where children experience emotional neglect or physical punishment that is abusive start out with the intention of causing harm to their children? Parenting is a challenge for many people—not just those who come to the attention of statutory services. Although parents may emerge from the birthing suite intent on loving and caring for their infant, life throws some "curve balls", and we disappoint ourselves. And I suspect that is the reality for the majority of parents encountering the child protection system. I am not aware of any empirical evidence to show that parents in the statutory system are typically sadistic and ill-intentioned. If they were, it would make the jobs of caseworkers and judicial officers of the children's courts very easy. But in the absence of such evidence, let us assume that parents of maltreated children are not necessarily callous, intentionally bad people. Life circumstances—whether of their own making or not—have led them down a path where their children are suffering.

The point of my argument is *not* that we should pity these parents or fail to intervene to protect children. Where the risk is too great to a child's wellbeing for them to remain in the care of their parent(s)—and where all reasonable avenues have been tried to support parents in creating environments free from abuse and neglect—it is society's obligation to intervene. But in the circumstance where we have experienced unsustainable growth in the number of children removed from their parents, and little data to show that growing up in alternative care is leading to substantially improved outcomes (Higgins & Katz, 2008)—the question remains: What more can be done?

Public health interventions

Recognition of the value of a public health approach to the problem of child maltreatment is reflected in the reframing of the policy approach to protecting children. The approach has moved away from focusing mainly on statutory responses to risk-of-harm reports ("tertiary services"), toward targeted services to those families potentially at risk ("secondary services"). There is also an acknowledgement of the need to combine these with primary prevention efforts, drawing on universal services to support the broader population of all families (see Bromfield et al., 2014; Hunter, 2011; O'Donnell et al., 2008; Scott, Higgins, & Franklin, 2012). However, I would argue that

universal services as a platform for taking action to shift the risk profile for the entire cohort of children are still lacking. The backbone of such public health interventions should be a suite of wide-scale, stepped or escalating interventions that can reach the broadest of audiences, but link to more specific services for those in need of additional supports.

A public health approach is premised on the understanding that risks to children's safety and wellbeing exist on a continuum, and that protecting children is everyone's responsibility, as is explicitly referenced in Australia's National Framework for Protecting Australia's Children 2009–2020 (Council of Australian Governments (COAG), 2009a). Similarly, a public health approach, focusing on the causes (also referred to as risk factors or social determinants) of violence underpins the National Plan to Reduce Violence Against Women and their Children 2010–2022 (COAG, 2009b). Although there is commitment to making child safety "everyone's business", as it stands, more of the "business" has been funded toward the statutory end of the spectrum (see the analysis of cost for child protection services reported by the Productivity Commission, 2015). Innovations are emerging, however, such as differential response models that invest in secondary services to prevent moderate-risk families needing to receive statutory services (Bromfield et al., 2014).

To fully see the benefits of a public health approach, we need to identify practical strategies to shift the balance of activities into the public health domain, and identify population-wide strategies that can be employed (i.e., primary prevention). Although targeted interventions can and are being applied toward the known drivers of statutory child protection concerns—namely, families experiencing the parental problems of mental illness, drug/alcohol misuse and violence—this does not itself constitute a public health approach. The emphasis should be on examining what are the precursors of child maltreatment (not

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just severe cases that come to the attention of statutory services) and putting in place actions to modify these on a population-wide level. Empirical data show that the clearest risk factors are problematic parenting behaviours (CFCA, 2013). Public health interventions begin with actions that are taken at a whole-of-population level, often through already existing universal service delivery platforms, where workers are already coming into contact with families (e.g., health, education, and child care services), complemented by community-based actions, and population-wide strategies (such as information, awareness-raising actions, regulations/controls, training, resources and supports) (see: Herrenkohl, Higgins, Merrick, & Leeb, 2015). Public health strategies have been used widely to deal with an array of health "issues", such as road deaths, alcohol misuse, smoking, and sexual health (prevention of HIV and other sexually transmissible infections).

Safe and supportive family environments

Parents vary in the degree to which they use positive, effective, non-violent parenting behaviours. Some families struggle to provide consistently warm, nurturing and safe environments. A key strategy in child abuse prevention is to address problematic parenting behaviours, which are seen as being the primary modifiable risk factor. For example, risk factors for child physical abuse include parenting characteristics such as low engagement and negative perceptions of the child (Cummings & Berkowitz, 2014).

The move towards a public health approach to child protection reflects, in some part, a move in research away from viewing parents who maltreat children as a distinct psychological category and towards viewing them as being at one end of a continuum that includes *all parents* (Azar, 2002; Belsky, 1984; Holden, 2010). Children experience varying levels of risks across this continuum, which at its negative end may present as child maltreatment or cold, unresponsive, highly neglectful or abusive parents.

Two of the core elements of a safe and supportive family environment relate to parenting and interparental conflict. Levels of parental warmth and hostile or angry parenting vary across families. At the extreme end, children may witness domestic violence between parents. However, interparental conflict arises in a broad range of families throughout society (Repetti, Taylor, & Seeman, 2002).

A safe and supportive family environment is one in which parents ideally provide warm, positive interactions and a secure base from which children can safely explore the world to learn about themselves, others and the wider world around them (Holden, 2010; Pettit, Bates, & Dodge, 1997). These families have well-defined (but not rigid) boundaries between parents and children, positive parenting practices, and parental discipline is consistently applied (Baumrind & Black, 1967; Lucas, Nicholson, & Maguire, 2011; O'Connor & Scott, 2007). As children grow it is important that they engage in shared activities with their parents (Wise, 2003). These are important opportunities to develop both cognitive and non-cognitive skills. For example, shared parent–child engagement in reading (Senechal & Schagen, 2002) and play (Tamis-LeMonda, Užgiris, & Bornstein, 2002) has a positive influence on children's cognitive, social and emotional development.

Researchers have identified a range of negative outcomes for children associated with poor parenting practices, including child aggression or social withdrawal (Pettit & Bates, 1989); and risky behaviour in adolescence (e.g., alcohol consumption; Alati et al., 2010). Risky family environments are characterised by parental anger or hostility towards children (Repetti et al., 2002). Although interparental conflict is an inherent part of any normal relationship, ongoing, high-level conflict is a feature of highly risky family environments and can lead to adverse psychological and behavioural outcomes for children (Cummings & Davies, 2010; Repetti et al., 2002; Zubrick et al., 2008).

Negative conflict tactics, such as hostility, elicit negative emotional responses from children, whereas positive conflict tactics, such as calm discussion, elicit positive emotional responses (Cummings, Goeke-Morey, & Papp, 2003). As well as being distressed by hearing and seeing interparental conflict, children could themselves be drawn in to—or become the focus or target of—arguments and conflict. Conflict can affect children indirectly through its negative effects on parenting, and it can provide a poor model of interpersonal relationships (Amato, 2006).

Population data on family environments

In order to examine the degree to which the family characteristics identified by Minuchin (1978) arise to some extent in all families, Mullan and Higgins (2014) analysed different types of family environments across Australia using the Longitudinal Study of Australian Children (LSAC)—a large, nationally representative study of two cohorts of children (5,000 recruited in infancy; and 5,000 in their kindergarten year, at age 4–5, and tracked every two years since 2004).[2] There are numerous measures of aspects of parenting and more limited measures of parental conflict used across the two cohorts within LSAC.

Mullan and Higgins' (2014) four key aims were to examine:

- the prevalence of different types of family "groups" or environments (cohesive, disengaged, enmeshed);
- the profile of these three "family environments" in terms of parenting characteristics (warm parenting, angry parenting), parent–child interactions (shared activities to capture positive parent–child interactions and reflect, in part, the extent to which parents are a resource that their children can access), and parental conflict, as well as the social, demographic and economic characteristics;
- whether these different family environments are associated with measures of child wellbeing; and
- whether positive changes in the family environment over time leads to improvements in child outcomes.

Using a statistical technique called latent class cluster analysis, Mullan and Higgins (2014) identified three broad family environments across a broad age range of study children, both in families with two resident parents and in families with a parent living elsewhere from the primary carer:

- **Cohesive**: The largest group of families exhibited average or above-average levels of parental warmth and parent–child shared activities, and below-average levels of hostile parenting and parental relationship conflict (i.e., clear but flexible boundaries) (see Kerrig, 1995). Cohesive families represent an exemplar of a safe and supportive family environment. As we would expect, these families were the majority, supporting the proposition that most Australian children live in safe and supportive environments.

- **Disengaged**: A smaller group of families exhibited below-average levels of parental warmth and parent–child shared activities, average or below-average levels of parental conflict and above-average levels of hostile parenting (see Minuchin, 1978). In such families, there are rigid boundaries (as demonstrated by lower parental warmth) and a tendency to close off access to resources for children.

- **Enmeshed**: The last group was a small number of families who had strikingly higher levels of parental conflict than the other two groups. They had average or slightly above-average levels of parental warmth and parent–child shared activities. These patterns arise in families with boundaries that tend to be diffuse, and these families have been referred to as enmeshed in previous research (see Minuchin, 1978). Higher levels of parental conflict that tends to negatively affect parenting and lower levels of parent–child interactions distinguish these family environments from the two other groups.

Distinguishing between different family environments

The results highlight that risks to children's safety and wellbeing operate along a continuum that spans all families. There was some limited association between dysfunctional family environments and socio-economic status (SES). At different points in children's lives, different aspects of SES are associated with particular aspects of family environments. In other words, there is not a consistent pattern. This provides some support for the validity of a public health approach to child protection, because it shows that factors associated with risks for children are evident to a greater or lesser degree across the entire population (as observed with nationally representative LSAC survey data). Of course, it is important to recognise that looking at parenting behaviour and parental conflict is not the only way to assess whether an environment is safe and supportive.

Often, statutory child protection authorities and the secondary service system (support

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for families needing extra assistance, with a focus on early intervention) focus their efforts towards low-SES families, where many of the risks of child maltreatment are congregated—either because service delivery (and surveillance) is concentrated in areas of geographic disadvantage or because services are otherwise allocated to those with the greatest apparent need. However, this is not to assume all children growing up in poverty have worse outcomes—or that all socio-economically advantaged children are doing well. The results that Mullan and Higgins (2014) reported suggest to some extent that potentially problematic dynamics within the families are not concentrated in particular socio-economic groups.

The targeting of services to those most in need could be enhanced by identification of families with problematic intra-familial dynamics and targeting people by behaviour rather than targeting people by demographic characteristics. Different family environments are likely have different needs requiring different types of responses.

Public health campaigns that address parenting practices across the population may be an effective means of addressing the more problematic family environments identified by Mullan and Higgins (2014), as population-wide screening of parenting behaviours may not be cost-effective and may have unintended consequences. However, existing services that come in contact with many parents (e.g., perinatal services, health, early childhood education and care providers, etc.) could have a role in identifying those with seriously problematic family dynamics for receiving additional services.

Family environments and child outcomes

Mullan and Higgins (2014) considered the associations between family environments and six measures of child wellbeing: weight status; injuries; social and emotional wellbeing; cognitive development; literacy; and numeracy.

There were few consistent significant associations between family environment and children's cognitive development. However, children in families located toward the disengaged end of the boundary range had, on average, lower reading and numeracy scores, even after controlling for other factors. Patterns were very similar across family environments for children in families with a parent living elsewhere from the primary parent.

There were few significant associations between family environment and children's health outcomes. Significant results were restricted to children 2–3 years living in families with two resident parents:

- Children aged 2–3 years in families lying toward the enmeshed end of the boundary range were significantly more likely to be underweight (than normal weight).
- Children aged 2–3 years in families located toward the disengaged end of the boundary range were significantly more likely to have two or more injuries per year.

Although there weren't strong relationships with later cognitive development and health outcomes, Mullan and Higgins (2014) found a different pattern in relation to children's social and emotional wellbeing:

- In families with two resident parents, children in families positioned toward the disengaged end of the boundary range had significantly lower levels of pro-social behaviour, higher levels of total problem behaviour, and higher levels of externalising problem behaviour when compared to children from more cohesive families.
- Results were very similar for children in families with a parent living elsewhere from the primary parent.
- There were also significant associations highlighting negative social and emotional outcomes for children in enmeshed families, but these were not as pronounced compared with the results for more disengaged families.

Do changes in family environment affect children's wellbeing?

Mullan and Higgins (2014) then went on to look at children whose family environment changed—and whether this change was reflected in children's outcomes. They found that across the two LSAC cohorts:

- 54–60% of families with two resident parents remained cohesive; in families with a parent living elsewhere from the primary parent, 62% of the birth cohort and 22% of the kindergarten cohort remained cohesive.
- In families with two resident parents, the family environment of 16% of the birth cohort children and 19% of the kindergarten cohort became more cohesive (15% and 20% respectively in families with a parent living elsewhere from the primary parent).
- Children in regional or rural areas were significantly less likely to experience a worsening of their family environment; children with two or more siblings were

significantly more likely to experience a worsening of their family environment.

■ Changes in family environments were significantly associated with changes in children's social and emotional wellbeing in families with two resident parents.

■ Children whose family environment improved (i.e., became more cohesive) showed improved social and emotional wellbeing. In contrast, children whose family environment worsened (i.e., became significantly less cohesive) exhibited increased social and emotional problems.

While changes in family environment were seen to have impacts in relation to children's social and emotional wellbeing, they were not strongly related to health or cognitive outcomes. The exception was for families with two resident parents, children 10–11 years old in families that transitioned toward the middle of the boundary range (that is, they became more cohesive) had significantly improved literacy.

Changes in children's family environment were significantly associated with changes in their social and emotional wellbeing. Children whose family environment moved closer toward one resembling cohesive families exhibited increased pro-social behaviour and decreased problem behaviour. The reverse was the case if their family environment moved away from being a more cohesive environment. Although these results relate directly to social and emotional wellbeing, it is important to emphasise that there may be links between socio-emotional outcomes and other child wellbeing outcomes (AIHW 2011; Hamilton & Redmond, 2010). Therefore, family environments that promote socio-emotional wellbeing are likely to have benefits for other domains of child wellbeing.

It is perhaps not surprising that Mullan and Higgins (2014) found that children's social and emotional wellbeing is most significantly associated with their family environment measured as a function of indicators of parent–child and parent–parent psychosocial interactions. This is consistent with the literature showing that children in families marked by higher levels of parental conflict also exhibit relatively poorer social and emotional outcomes. The particularly strong negative effects for children in families with lower parental warmth and involvement point to the importance of the family in providing children with a secure base and a sense of connection or togetherness (Bowlby, 1988).

Implications for policy

The results of Mullan and Higgins' (2014) analysis supports a public health approach by demonstrating in a large-scale representative sample the variability in children's outcomes, the prevalence of suboptimal family environments (enmeshed and disengaged), and the improvements in wellbeing that occur when children's family environments become cohesive.

With respect to identifying different family environments, Mullan and Higgins (2014) found firstly, that different family environments were able to be identified; secondly, that they are not strongly related to factors we would normally associate with difficulties with the family affecting child welfare (such as socio-economic factors); and finally, that family environments do change—and that these changes can affect children's wellbeing.

The aim of a public health approach to protecting children is to shift the focus away from a narrow band of children requiring statutory intervention toward addressing the needs of all families, and to move the population distribution on risk factors—such as poor parenting skills and dysfunctional family dynamics—toward the positive end for all families. Shifting the profile of all families would potentially reduce the number that would be at risk of statutory intervention and improve the daily lives of many children. In terms of public health interventions, three possibilities arise, and this study may provide some helpful insights. The three potential types of interventions are (a) parenting programs and supports; (b) public information programs; and (c) targeted referrals for more intensive family support (i.e., progressive or proportionate universalism).

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> While parenting programs and home visiting programs have been shown to improve parenting skills, there is not strong evidence that they are sufficient to prevent child maltreatment.

(a) Parenting programs and supports

Parenting programs have been widely used in early intervention strategies targeted toward vulnerable families (Hayes, 2014).[3] However, some argue that parenting programs can be delivered as part of a public health approach to strengthen and support parenting (Sanders, 2008), and to prevent child maltreatment (Sanders, Cann, & Markie-Dadds, 2003; Sanders & Pidgeon, 2011). Prinz, Sanders, Shapiro, Whitaker, & Lutzker (2009) provided evidence showing a significant prevention effect following from the delivery of a parenting program in the United States. An Australian example, the Every Family initiative, trialled the delivery of the Triple P-Positive Parenting Program in 30 sites across three Australian cities—Brisbane, Sydney and Melbourne (Sanders et al., 2005; see <triplep.net>). As identified by Sanders et al., for success in a public health initiative of this nature it is necessary to have a good understanding of the prevalence of the particular problem behaviours in children being targeted, the prevalence of parent risk and protective factors, and evidence that changing risk and protective factors improves child outcomes. (See the article by Pickering & Sanders on page 53).

There is a range of other evidence-based approaches to supporting parents and addressing problematic parenting behaviour—for example, through individual parenting education, counselling and mediation (particularly in the context of parental separation). Parental education and support is also a key feature of home visiting programs

(see Holzer, Higgins, Bromfield, Richardson, & Higgins, 2006), and a range of other evidence-based interventions for families (Casey Family Programs, 2012). Wise, da Silva, Webster, & Sanson (2005) provided other examples of parenting supports and early childhood interventions whose efficacy is supported by good research evidence.[4]

A large body of research provides strong evidence that the home environment—in particular, concrete behavioural patterns of parents (i.e., parenting characteristics)—is an important determinant of children's early development and wellbeing. However, it should be noted that, while parenting programs (even those with the highest evidence of their effectiveness, particularly those that are modularised, structured, manualised, etc.) and home visiting programs (a suite of services that may include particular components such as parenting programs and coaching or mentoring) have been shown to improve parenting skills, with the notable exception of Prinz et al. (2009), there is not strong evidence that they are sufficient to prevent child maltreatment (Casey Family Programs, 2012; Holzer et al., 2006; Mildon & Polimeni, 2012).

(b) Public information campaigns

Public information programs are a more familiar tool used by governments to effect broader changes in the behaviour of the population in general. Examples abound, including public health campaigns around alcohol, smoking, skin cancer, drink-driving and safe-driving campaigns. A recent Australian campaign that highlighted how parental alcohol consumption affects children offers an interesting template for how such campaigns can be used to educate parents about the influence their behaviour has on children.[5]

Consistent with the World Health Organization Ottawa Charter for Health Promotion,[6] a range of actions can be taken to improve outcomes, based on advocacy, enabling people to take control of factors that affect their wellbeing, and mediating between differing interests in society for the pursuit of health. They need to be targeted at attitudes or behaviours that are modifiable, with clear links to strategies for achieving the desired change. Adopting a broad information campaign may have limited effect if it is not directed toward behaviours that can be changed and does not point to sources of support for bringing about that change. For example, the national and state/territory Quit initiatives are effective in responding to the problem of smoking because it is targeted at broad social attitudes as well as suggesting

concrete actions and providing access to supports for quitting smoking.[7]

Research has explored the utility of popular media to promote positive parenting practices more generally (Sanders & Prinz, 2008) and to promote the prevention of child maltreatment (Saunders & Goddard, 2002). Although public information programs can assist, there are limitations to their effectiveness, particularly when knowledge or attitudes alone are insufficient to effect change. There is limited evidence to address the question of whether or not social marketing campaigns are effective in addressing concrete outcomes like rates of child abuse and neglect (unless linked to a suite of other parenting supports and interventions, proportionate to the needs of parents; see Pickering & Sanders on page 53). Also, evaluations of public information campaigns are notoriously difficult to conduct with any rigour (Horsfall, Bromfield, & McDonald, 2010).

(c) Targeted referrals for more intensive family support

Often the distinction between universal and targeted services is presented as a dichotomy; however, there is scope for it to be seen as a continuum, with universal services being the platform for the ramping up or integration of services that would then be classified as targeted. The principle of proportionate universalism (or progressive universalism, as it is also termed) was outlined in the Marmot review of the social determinants of health inequalities in the United Kingdom (see *Fair Society, Healthy Lives: The Marmot Review*).[8] According to this principle, actions must be "proportionate to the degree of disadvantage, and hence applied in some degree to all people, rather than applied solely to the most disadvantaged" (Lancet, 2010, p. 525). It is also important to remember that disadvantage is not static—families (or even communities) can move into and out of disadvantage (Qu, Baxter, Weston, Moloney, & Hayes, 2012).

Although child abuse and neglect (particularly child sexual abuse) occur across all family forms and socio-economic strata and are under-reported, poverty and social disadvantage are generally associated with higher risks of harm, particularly from neglect (Higgins, 2010). Key issues relating to the economic security of families are the availability and adequacy of employment, and systems to support families on low incomes or experiencing unemployment, such as housing, health care and income support, as well as job search and other employment-related services (Adema, 2012; Howe, 2012). Although Australia has a relatively low level of joblessness overall, the number of Australian families in which no adult member of the household is in paid employment is high compared to many other Organisation for Economic Co-operation and Development (OECD) countries. This is the single most important cause of child poverty in Australia, and has been linked to poorer developmental outcomes for children (Hand, Gray, Higgins, Lohoar, & Deblaquiere, 2011). Jobless families are therefore reliant on government income supports. In the past couple of decades, many government payments have become conditional, in an attempt to address concerns about the welfare of children. An example is compulsory income management or welfare quarantining, which aims to ensure household expenditure on priority items that meet children's needs rather than gambling, pornography, alcohol and junk food, particularly in circumstances where authorities have concerns about child neglect (Taylor, Stanton, & Gray, 2012). Such conditionality is directly or indirectly aimed at shaping parental behaviours and the family environments in which children grow up.

Although services targeted at the most disadvantaged have the greatest impact, it is also true that targeted services would then mean the majority of the population misses out on the particular interventions. Mullan and Higgins (2014) have demonstrated through their analysis of a representative sample of Australian children that less-than-optimal parenting practices and family environments are not restricted to particular demographic groups and cannot be easily targeted—so there is value in considering the role of universal services to deliver information, supports and services for all Australian families, with increased intensity for those who need it most. Universal services can provide the platform to refer people who require them to more specialist services, or provide a continuum of service, so that within the universal service platform more intense services can be provided to those in need. A number of authors have argued for the importance of using universal services as a base or soft-entry point for engaging families that might otherwise be hard to reach (Muir et al., 2009; O'Donnell et al., 2008; Scott, 2006).

Children identified as being at highest risk tend to be concentrated in circumstances of relatively high disadvantage; however, a public health approach would seek to broaden the policy focus to address wider needs that will make positive changes for the bulk of the population. The research is intended to inform policies to address most Australian families, so that child protection systems have to deal

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with a decreasing proportion of families for whom a public health approach is not enough. However, other examples of vulnerability over time might include parental separation, which increases the risk to the safety and wellbeing of children. Family courts often face difficult choices when parents raise concerns about child abuse or violence by their partner during disputes over children's matters (Croucher, 2014; Higgins, 2007; Kaspiew et al., 2009).

Further research is needed that explores in more depth the population prevalence of parenting skills, family environments and other characteristics associated with the risk of child abuse and neglect, and the various transition points or "vulnerabilities" across the life-cycle for families where children's wellbeing may be at greater risk.

Conclusion

Building on the growing consensus that communities are best served by a public health approach to child protection (COAG, 2009a), in this article I have taken this one step further, and—drawing on empirical evidence outlined in detail in Mullan and Higgins (2014)—demonstrated "proof of concept" that it is possible to identify family environments at a population level that could be the subject of public health interventions. In broad terms, representative population-based data show there are distinct family environments across society that are similar in certain factors associated with parent–child and parent–parent interactions, and that these groups are not directly linked to particular socio-economic groups. The majority of families were cohesive.

A smaller—though substantial—group were disengaged. A third group, equally substantial, were enmeshed.

Different family environments, with their dynamic nature, have a strong influence on certain child outcomes, particularly those relating to children's social and emotional wellbeing. Children with warm, highly involved parents had higher social and emotional wellbeing. Those with less involved parents, and who experienced above-average angry parenting, tended to have lower social and emotional wellbeing. Children in families marked by higher levels of parental conflict were between these two groups. This highlights the importance of parent–child and parent–parent interactions in shaping aspects of the family environment to which children's social and emotional wellbeing are sensitive.

However, I think the most significant aspect of the analysis provided by Mullan and Higgins (2014) was that due to the longitudinal nature of the LSAC dataset, these environments were examined repeatedly over time from infancy to middle childhood. There was considerable change in the family environments for children—and most importantly, that positive changes (where families scores on the measures moved towards the more "cohesive" end of the spectrum), were associated with improvements in children's social and emotional wellbeing (though the pattern was not as evident in relation to educational outcomes). The reverse was also true: wellbeing deteriorated for children whose family environments became less cohesive.

This highlights the potential for public health interventions aimed at improving—and sustaining—dimensions of the family environment that are strongly associated with children's social and emotional wellbeing (Hunter, 2011). A public health approach draws on families' strengths, but seeks to support all families to do a better job of providing children with a safe and supportive environment, reducing the likelihood of exposure to violence, maltreatment or neglect (Scott, 2006). Possible interventions include parenting programs and public information programs. Careful tailoring of interventions to specific dynamics arising within families would be beneficial, and programs that can reach a broad cross-section of society are necessary.

Rather than seeing the protection of children solely as the role of statutory authorities, a public health perspective sees the opportunity for all families to have supports to improve their capacity to protect children and creating safe environments for them. However, it is

not sufficient to simply "bolt on" preventive programs to the current child protection processes. Researchers and commentators have argued that the role and function of child protection systems need to be reviewed in the context of the wider range of policies and programs aimed at supporting parents and promoting the wellbeing of children. This is of particular importance in the context of minority and/or marginalised groups, such as Indigenous communities in Australia, for two reasons: (a) Indigenous children are over-represented in statutory child protection activities in Australia (and similarly with First Nations peoples in Canada; see National Collaborating Centre for Aboriginal Health, 2013); and (b) community-owned and community-led initiatives can be used to support the health, wellbeing and safety of Indigenous children in culturally appropriate ways (Higgins & Katz, 2008).

I am not suggesting that community-wide interventions to identify and ameliorate poor parenting practices should occur at the expense of statutory services, or of early intervention services to those at high risk. I am instead arguing for a "proportionate" or "progressive" universal approach: as well as communitywide interventions (parenting campaigns), linked to easily accessed information and services for those parents wanting assistance, further work would need to be done to identify how existing universal service providers who are in touch with families could be used to identify such problematic environments, and re-engage them in an evidence-based practice to improve their parenting capacity and the family environment. This could include a range of services such as antenatal services, maternal and child health services, early childhood educators and schools. These represent the existing service infrastructure that all families access. In addition, where there are points of crisis in a family's life—like a serious illness, parental unemployment, a bereavement or separation/divorce—then the services that interact with families at these times could be provided with resources and training to screen for, and provide additional support for, families at risk of slipping into a less positive environment. This could include government agencies providing financial assistance to the unemployed or managing child support arrangements post-separation, family relationship services to separating couples (such as those providing mediation services or conducting assessments for family courts), and hospital social-work staff.

Families remain the central focus of identifying risks of maltreatment of children (which are often characteristics or behaviours of

parents); families are also central to strategies for protecting children. Although families are not always the only site of violence and maltreatment of children, they can still—along with other agencies and institutions—be enlisted to assist with interventions to support children and keep them safe. Even in relation to prevention of child sexual abuse, while most abuse occurs in families or by known perpetrators, when it does occur outside of the family, families can still play a protective role to prevent abuse, and respond appropriately if it does occur.

The association between family environments and child wellbeing outcomes (especially around social and emotional wellbeing) suggest that the efficacy of policy may be enhanced if policies and services: (a) are attuned or sensitive to different family environments; (b) target behaviour (parental family dynamics) rather than people on the basis of their socio-demographic characteristics; (c) recognise both that families can change for the better and that they can potentially draw on their own prior (positive) experiences; and (d) are directed to all families (e.g., through universal services), based on a public health approach to promote safe and supportive family environments.

All families have a vital role to play in providing children with a safe and supportive environment. The public health space provides governments, agencies and communities with opportunities to recognise that problematic family environments could arise in any family at any time and appropriately intervene.

Endnotes

1 Children removed from the care of their parent(s) and placed in "alternative care" due to their family environment being so unsafe that their wellbeing would be seriously compromised if they were not removed are referred to as "looked after children" (e.g., in the UK).

2 Parents answered a number of questions relating to warm parenting (e.g., "How often do you hug or hold this child?"; "How often do you tell this child how happy he/she makes you?"). The "primary" and "secondary" resident parents/carers answered a number of questions relating to angry parenting (e.g., "How often are you angry when you punish this child?"; "How often have you lost your temper with this child?"). The primary parents and the parents living elsewhere from the primary parent stated how often during the week prior to the interview they had read or told a story to the study child, played indoors or outdoors with the study child, engaged in music or other creative activities with the study child, or included the child in everyday activities. In families with two resident parents, both parents answered questions relating to parental conflict (e.g., "How often is there anger or hostility between your partner and you?"; "How often do you have arguments with your partner

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A public health approach draws on families' strengths, but seeks to support all families to do a better job of providing children with a safe and supportive environment, reducing the likelihood of exposure to violence, maltreatment or neglect.

> It is not sufficient to simply "bolt on" preventive programs to the current child protection processes.

that end up with people pushing, hitting, kicking or shoving?"). In families with a parent living elsewhere from the primary parent, the primary resident parent also answered questions relating to conflict with the other parent. The measure of interparental conflict was based on responses to a single question about how well the other parent gets along with the study child's primary responding parent. For information on LSAC, see: <www.growingupinaustralia.gov.au>

3 For an example of a state/territory initiative, see: Brighter Futures <www.community.nsw. gov.au/brighter_futures_program.html> and a Commonwealth initiative, Stronger Families and Communities Strategy <tinyurl.com/pcocpdv>. Similarly, in the USA, the Centers for Disease Control and Prevention has developed the Essentials for Childhood Framework (see Herrenkohl et al., 2015).

4 See Holzer et al. (2006) for other examples of parenting programs that have been evaluated. For a comprehensive summary of profiles of programs that have a good evidence base, see <apps.aifs. gov.au/cfca/guidebook/programs>. For a list of other publications on parenting programs, see also: <www.aifs.gov.au/cfca/topics/parenting.php>. Casey Family Programs (2012) published a synthesis of evidence-based interventions that address common forms of maltreatment—many of which are focused on improving parenting capacity. For further information on the evidence base for home-visiting interventions, see: <www.casey.org/home-visiting>. Mildon and Polimeni (2012) reviewed programs that have specifically targeted Indigenous families.

5 For example: DrinkWise Australia's "Kids absorb your drinking" campaign <drinkwise.org.au/campaigns-initiatives/kids-absorb-your-drinking>; DrinkWise Australia's "Under your influence" campaign <drinkwise.org.au/videos-mobile>; and NAPCAN's "Children See: Children Do" campaign <napcan.org. au/children-see-children-do>.

6 See the Ottawa Charter for Health Promotion at: <www.who.int/healthpromotion/conferences/ previous/ottawa/en/index.html>.

7 See Quit Now <quitnow.gov.au>, Quit <quit.org.au> and VicHealth <www.vichealth.vic.gov.au>.

8 See the Marmot Review at: <www.marmot-review. org.uk>.

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Families remain the central focus of identifying risks of maltreatment of children (which are often characteristics or behaviours of parents); families are also central to strategies for protecting children.

> The public health space provides governments, agencies and communities with opportunities to recognise that problematic family environments could arise in any family at any time and appropriately intervene.

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