LA TROBE UNIVERSITY

JUDITH LUMLEY CENTRE
for mother, infant and family health research

SUBMISSION TO THE HUMAN RIGHTS COMMISSION
15 June 2015

Examination of children affected by family and domestic violence

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ENQUIRIES

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SUBMISSION: Examination of children affected by family and domestic violence

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SCOPE

This document is a submission to the Australian Human Rights Commission National Children's Commissioner as evidence to support the Children's Rights Report 2015. It addresses the following questions posed in the request for submissions:

2. What do we know about the prevalence and incidence of family and domestic violence affecting children, including who is involved in family and domestic violence events?
3. What are the impacts on children of family and domestic violence?
4. What are outcomes for children engaging with services, programs and support?
6. What are the surveillance and data gaps/needs in relation to children affected by family and domestic violence?

This submission draws on work being undertaken for a 'State of Knowledge' report currently being prepared by the authors for Australia's National Research Organisation for Women's Safety (ANROWS). The ANROWS report is the first stage of a larger research project on *Domestic and family violence and parenting: mixed method insights into impact and support needs* and we wish to acknowledge funding from this organisation to complete the work.

KEY POINTS

- The prevalence of children affected by family and domestic violence (FDV) is difficult to estimate due to limitations within the data, however evidence from a range of sources suggest that women and children are exposed to significant rates of FDV.
- There is now a large body of evidence to suggest that children suffer considerable health problems from their experiences of violence in the home.
- FDV is associated with compromised parenting. Women strive to be 'good' mothers but the lack of control and stressful context of a violent environment reduces women's ability to parent effectively. Impaired parenting due to violence can result in disordered infant attachment and disruption of the mother-child bond.
- The most commonly reported symptoms children exhibit include internalising and externalising behaviours such as anxiety, depression and behavioural problems.
- Best practice suggests children exposed to FDV have both individual and group therapy with the non-abusive parent.
- Findings from the MOVE study indicate the Maternal and Child Health (MCH) nurse screening and care intervention to be effective in increasing safety discussions with postpartum women who disclose FDV.

RECOMMENDATIONS

Current action:

- Improve data collection methods to accurately measure and monitor trends among the proportion of families with children exposed to FDV.
- Improve capacity to link data across health and other systems (e.g. police and hospital data).
- Promote use of trained and supported mentor mothers for abused pregnant women or new mothers to improve mothers' mental health and parenting confidence.
- Increase federal, territory and state Government support for/monitoring of accreditation in undergraduate and postgraduate education and skill development for health care professionals responding to victims of abuse.
- **In Victoria**
    - state-wide implementation of the MOVE model into the current Department of Education and Training, Maternal and Child Health service practice guidelines to support the current family violence work completed by nurses, including all aspects of the model and extension of the model to other states .
    - MCH nurse teams to provide a later (ideally 3-month) focussed mother's health consultation to address mothers' health needs, including asking about family violence.
    - All MOVE clinical resources including the crucial maternal health and wellbeing checklist to be made available to MCH teams state-wide.
    - Link MCH teams with individual regional family violence service workers to support nurse FDV work and improve inter-sectoral collaboration.
- **Nationally**:
    - Develop an implementation plan to extend the MOVE model to other states, taking account of differences in things such as service models, staffing, inter-departmental collaboration and funding.
    - Increase funding for family violence services, allowing improved collaboration with nurses and other early intervention work instead of crisis-only services.
    - Improve data collection methods within MCH services to measure trends in family violence prevalence and responses in the MCH child and mother client population and the family violence work of nurses and the ability to link/compare with other Family Violence Index data sources.

Further research on:

- Greater understanding of how the mother-child relationship is altered due to FDV.
- Lived experience of abused women as parents and the mother-child relationship.
- Parenting behaviours of abusive men and the father-child relationship.
- Intervention aimed at programs to support the mother-child bond and heal relationships.
- Investigation of adaptations needed to the MOVE model to be implemented in other Australian states and territories, with evaluation follow up.
- Whether MCH nurse family violence routine screening or risk assessment methods are effective in the longer term for improving outcomes for women and children.
- The impact/outcomes of nurse safety discussions with women attending MCH services.
- How enhanced MCH services respond to high-risk families experiencing FDV.
- An effective model for MCH nurses to engage with migrant/refugee and Aboriginal families experiencing family violence.

ABOUT THE AUTHORS

Leesa Hooker is a Maternal & Child Health nurse, midwife and academic at the La Trobe Rural Health School in Bendigo, Victoria. She has been working in the area of women's and children's health for the past 20 years and commenced her PhD (at JLC) titled Strengthening MCH nurse practice for vulnerable families, especially those experiencing family violence, in 2013. This research has involved evaluation of a randomised trial of a family violence intervention for MCH nurses to improve identification and support for women and children experiencing family violence. Her research interests include intimate partner violence, women's health and improving health care service response to abused women and children.

Angela Taft is Professor/Director of the Judith Lumley Centre (JLC), La Trobe University, Australia and an Honorary Senior Fellow in the Department of General Practice, University of Melbourne. She is a social scientist using rigorous combinations of qualitative, randomised intervention trial evaluations and epidemiological methods to answer urgent and complex questions about women's health. Over the last fifteen years she has led a major competitively funded program of research at JLC on intimate partner/gender-based violence.

Jan Nicholson is the Inaugural Roberta Holmes Professorial Chair for the Transition to Contemporary Parenthood Program in the Judith Lumley Centre, La Trobe University. She has a background in psychology and public health. Jan has extensive experience in longitudinal studies of the effects of family, socioeconomic and institutional (services, school and workplace) influences on the health and wellbeing of parents and children, and the development and evaluations of community-based programs for preventing family-related health problems.

Elizabeth Westrupp is a Research Fellow in the Transition to Contemporary Parenthood Program in the Judith Lumley Centre, La Trobe University. She is a clinical psychologist and an early career researcher, who has focused her research efforts on understanding the biological, social and environmental factors that influence children's long-term developmental outcomes. She has expertise in clinical and population-level longitudinal research and cohort studies, and randomised control trials of parenting interventions across both the hospital and community settings.

ABOUT THE JUDITH LUMLEY CENTRE

The Judith Lumley Centre is a multidisciplinary public health research centre in the College of Science, Health and Engineering at La Trobe University. Established in 1991 by Judith Lumley, the Centre has built a strong program of research addressing issues of major public health importance for mothers, infants and families. The Centre emphasises the need for research, service development, evaluation and policy to be linked. Research spans the development and testing interventions in randomised trials, research translation into clinical practice, and implementation of effective and cost-effective interventions. The research focus areas at the Judith Lumley Centre include

- Mother and infant health
- Reducing violence against women and children.
- Sexual and reproductive health
- Transition to contemporary parenthood
- Maternity care and family services in the early years
- Breastfeeding

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PREVALENCE OF FAMILY AND DOMESTIC VIOLENCE (FDV)

Submission Question 2: What do we know about the prevalence and incidence of family and domestic violence affecting children, including who is involved in family and domestic violence events?

Submission Question 6: What are the surveillance and data gaps/needs in relation to children affected by family and domestic violence?

Family and domestic violence (FDV) is a significant social and public health issue affecting many women and children(1). Witnessing FDV is a form of child abuse and neglect (2, 3). Children have been identified as being most vulnerable to poor development, health and wellbeing when raised by parents with mental health or substance abuse difficulties or when they are exposed to FDV (3).

Overwhelming evidence suggests that it is predominantly women and children who are the victims of FDV and men are the perpetrators of abuse(1). The prevalence of FDV amongst parents and subsequent child exposure rates are difficult to estimate. National and state systems that collect data on violence and children are limited, spread across sectors and not easily accessible (4). In the wider academic literature, research samples vary, along with definitions of FDV and measures used. FDV measures based on conflict may not capture the coercive and controlling psychological violence that is so detrimental to women and children(5). Methodological variations and the many barriers to reporting FDV means that caution is needed when interpreting results.

With these caveats in mind, research suggests that Australian children are frequently exposed to parental aggression and FDV (2, 6).

- The 2012 Australian Personal Safety Survey (PSS) (n=17,050) reports on violence experienced (in the past 12 months) by men and women over the age of 18 years. Data include rates of abuse during pregnancy and the numbers of children witnessing DFV. Seventeen percent of women have experienced violence by a current or previous partner since the age of 15. Fifty four percent (54%) of all women who experienced violence by a previous partner and were pregnant during the relationship, experienced violence during pregnancy. One quarter (25%) experienced violence for the first time during pregnancy. Women abused by a previous partner were more likely than men, to have children in their care. Three quarters (77%) of women who experienced previous partner violence and had children in their care when the abuse occurred, reported that the violence was seen or heard by children (7).
- Australian postpartum women with infants under 12 months have reported rates of intimate partner violence ranging between 13.9-17% (8, 9).
- Households where a violent parent is present are significantly more likely to have children in attendance, especially children under 5 years (2, 10, 11). Victorian Police data (2013-2014) report children present in approximately 34% of households attended by police FDV incidents (12).
- In 2013-2014, up to one third (87,744) of all Australians seeking homelessness services were escaping FDV, the majority were sole parents (46%), mostly women and children(13).
- Population representative data from Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC: http://www.growingupinaustralia.gov.au/) show that over a six-year period, more than 1 in 3 mothers (35–36 %) reported any verbal and/or physical conflict. Extrapolated to the Australian population, this means that an estimated 1.9 million Australian children are likely to be affected by inter-parental conflict within any 6 years of the early-to-middle childhood period. The point prevalence (i.e. rate a single time point) was largely consistent across early-to-middle childhood, and was higher for verbal conflict (10–13 %) than physical conflict (4–10 %), and there was low co-occurrence of both verbal and physical conflict (1–3 %)(6).

- In later waves of data collection, LSAC added included a single item indicator of maternal fear of her partner. The point prevalence was consistent across children aged 6, 8, 10 and 12 years, with around 6% of mothers reported being fearful of their partner (Authors' unpublished data).

Data Gaps: There are limited studies on prevalence of FDV amongst diverse parent populations (Culturally and linguistically diverse, disabled, lesbian, gay, bisexual, transgender and intersex) including rural and remote parents and children (14, 15). Improved collection methods are needed to capture the proportion of parents and children experiencing FDV(16).

IMPACTS OF FDV ON CHILDREN

Submission Question 3: What are the impacts on children of family and domestic violence?

Submission Question 6: What are the surveillance and data gaps/needs in relation to children affected by family and domestic violence?

Research has consistently shown that children directly exposed to FDV have higher rates of a range of behavioural, mental and physical health problems. For example, children exposed to FDV are more likely to have mood and anxiety problems, attention deficit hyperactivity disorder, and conduct or oppositional/defiant disorder. Evidence has also demonstrated that exposure to FDV is associated with child physical health problems such as injury, asthma and obesity (17-24).

Parenting and FDV

Children may also be indirectly influenced by FDV via their parents, for example, through changes in parenting practices/capacity and the quality of the couple relationship. Many mothers experience trauma and negative physical and mental health consequences associated with FDV. These factors, together with the undermining tactics by perpetrators, are known to influence women's ability to function and parent effectively (25-27).

There is a considerable body of evidence showing deficits in maternal parenting resulting in the use of harsher parenting styles (28) and interruption in the mother-infant/child bond (29). Nevertheless, the evidence about the impact of violence on mothering in the context of FDV is mixed (28); women who experience FDV also report 'finding strength' in their mothering role (30) and make every attempt to protect their children.

Data Gap: There is limited research on the parenting behaviours of fathers who abuse their partners (31).

IMPACTS OF FDV SERVICES, PROGRAMS, AND SUPPORTS ON CHILDREN

Submission Question 4: What are outcomes for children engaging with services, programs and support?

Submission Question 6: What are the surveillance and data gaps/needs in relation to children affected by family and domestic violence?

State Legislation and Services

Current Australian state and territory laws on mandatory reporting of children exposed to FDV vary across jurisdictions(32). Legislation that mandates health care professionals to report children within violent families

may cause an overloaded child protection system(33) and significant damage to mother-child relationship and further alienate women from their children. This causes a double victimisation effect where mothers and children are victims of the perpetrator abuse and also abuse from the 'system' (34). Silo operations where women are offered assistance through FDV services that offer a woman centred approach differ from child protection services that are child centred. Feminist researchers argue for interventions to help heal the mother-child relationship rather than offer separate child and parent therapies (25). The World Health Organisation now recommends children who have been subjected to intimate partner violence undergo both individual and group psychotherapeutic treatment sessions with their mothers (35). Unfortunately, previous group work (in Melbourne) with mothers and children has not been sustained due to lack of funding (36, 37). More research and intervention work is needed to support the mother-child bond in the aftermath of FDV(38).

Early identification and support

Women and children affected by FDV benefit from early identification and support (39). The predominant focus in research on women as victims may have resulted in women being pathologised, rather than on the potentially more helpful focus being on the perpetrator of the abuse and his methods that undermine women's parenting (40, 41). The psychological, health and socio-economic impacts on children witnessing or exposed to FDV indicate that holistic care is required, with a focus on prevention, early identification (2) and interventions to support the disrupted mother-child relationship (25, 42).

CASE EXAMPLE: MOSAIC – Peer mentor mothers to support abused pregnant women and new mothers

One intervention tested in a randomised controlled trial in Victoria, replicated successfully in the Netherlands and being trialled in Nicaragua is the Mothers Advocates in the Community (MOSAIC trial) which provides trained and supervised volunteer mentor mothers for up to twelve months for pregnant women or new mothers identified as abused. Women were identified by their GPs or MCH nurses but could be referred from other places (43). This study and the one in Netherlands found that the use of mentors reduced both the levels of abuse and depression among mothers and mothers reported feeling better about themselves as parents (44).

The Victorian Maternal and Child Health Service

The Victorian Maternal and Child Health (MCH) service has been recognized as a cornerstone of Victoria's preventative services in addressing and preventing vulnerability. The Cummins report into protecting Victoria's vulnerable children suggests a strong universal and enhanced MCH service is needed for vulnerable families and that more evidence is required into interventions to reduce vulnerability (3). Improvements are required in the way nurses and services care for families with additional needs (3, 45). Improving MCH nurses capacity to identify and support vulnerable women and children experiencing violence is one way to address this need.

The Victorian MCH service is a "universal health service for children from birth to school age, focusing on promotion of health and development, prevention, early detection and intervention for physical, emotional and social factors affecting young children" (46). MCH services, governed by the Victorian Department of Education and Training (DET) are located within local government and provided by registered nurses who are qualified midwives with further postgraduate qualifications in MCH. MCH nurses are community based health professionals, with existing links and working knowledge of local allied health professionals and other services to support vulnerable families.

In 2009 the DEECD (now DET) introduced a new 'Key Age and Stage' (KAS) practice framework to the Victorian MCH service (47). This policy change involved a comprehensive evidence-based primary health care program, with the aim of improving child health outcomes. The new framework included the introduction of mandatory, routine FDV screening (47). Whilst nurses have always been cognisant of FDV in the community, previous

practice was to ask women about their exposure to violence based on risk assessment rather than routine asking.

CASE EXAMPLE: MOVE – Improving Maternal and Child Health nurse care for vulnerable mothers.

Earlier FDV research with MCH nurses (44) identified barriers to identification of abused women. MCH nurses also felt underprepared to address FDV with women(48). The MOVE randomised controlled trial included implementation of a best practice model of nurse screening and supportive care for women attending the MCH service. The MOVE model had been carefully developed within a theoretical model to improve sustainability(49) with six months active involvement of MCH nurse consultants to ensure the model responded to nurses' concerns as well. It consisted of focussed maternal health visits, a self-completion, maternal health and wellbeing checklist, which included maternal health and FDV screening questions, and a FDV clinical practice guideline and pathway (50). Enhanced contacts with local FDV services were also included in the model. A designated FDV liaison worker was appointed to nurse teams and nurse mentors acted as change agents to support MCH nurse FDV work and implement the model.

MOVE was implemented for 12 months in eight MCH teams in Melbourne's North West metropolitan regions. Extensive trial evaluation identified improved asking and safety discussions with women. Intervention nurse teams screened more women using the MOVE checklist and completed three times more safety planning(9). At two year follow-up, results indicate an increased and sustained practice change with a now, four-fold increase in safety planning.

Process evaluation identified that the MOVE maternal and health and wellbeing checklist (completed by mothers) was the most helpful resource for nurses, facilitating identification, nurse client interaction and supportive care. Use of this checklist at a specific maternal health visit allowed nurses more time to address women's health needs including FDV. Workloads, privacy issues, lagging knowledge and limited reflective practice continue to be barriers to FDV screening(51).

The MOVE intervention enhances nurse-mother interactions and increases the amount of safety planning discussions with women and children at risk of abuse. Interventions such as MOVE that offer women pathways to safety may ultimately reduce children's exposure to FDV.

In consideration of the above research, we have made recommendations and suggest future work that is needed in this area to identify, protect and support women and children experiencing family violence.

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