The Royal Australian & New Zealand College of Psychiatrists

17 June 2015

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission
GPO Box 5218
SYDNEY NSW 2000

By email to: kids@humanrights.gov.au

Dear Ms Mitchell

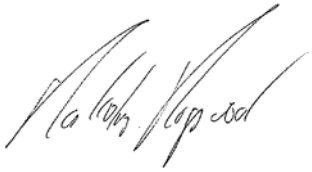
Re: Examination of children affected by family and domestic violence

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback into the Australian Human Rights Commission's (AHRC) examination of children affected by family and domestic violence. As the national conversation on family violence grows it is essential that the voices of children are heard and their support needs met.

Family violence incurs a huge cost on the individuals, families, community and society at large. In purely financial terms, it is estimated that the cost of family violence to the Australian economy each year is $9.9 billion. The real cost to mental health is untold – first come the mental health impacts in childhood, second come the mental health outcomes, often during adulthood, and so the cycle goes on. In this context, it is clear that investing in family violence prevention, early intervention and treatment is not only essential from a human rights and recovery perspective, but also from an economic perspective.

If you would like to discuss any of the issues raised in the submission, please contact Ms Rosie Forster, Senior Manager, Practice, Policy and Partnerships via rosie.forster@ranzcp.org or by phone on (03) 9601 4943.

Yours Sincerely



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Australian Human Rights Commission examination of children affected by family violence

June 2015

maximising opportunities for recovery

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Royal Australian and New Zealand College of Psychiatrists submission

About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness and advises government on mental health care. The RANZCP is the peak body representing psychiatrists in Australia and New Zealand, and as a binational college has strong ties with associations in the Asia-Pacific region.

The RANZCP has more than 5000 members, including around 3700 fully qualified psychiatrists and almost 1200 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental health care in the community and use a range of evidence-based treatments to support a person in their journey to recovery, including pharmacotherapy and psychotherapy.

Executive summary

The RANZCP welcomes the opportunity to make provide feedback to the Australian Human Rights Commission's (AHRC) examination of children affected by family and domestic violence. The RANZCP commends the AHRC for ensuring that the experiences and needs of children and young people are included in the growing national conversation on family violence.

It is essential that there is specific recognition of the impact of family violence on children and young people. Children are amongst the most at risk group affected by family violence, given their unique vulnerability, dependence and sensitivity to the emotional distress and suffering of their caregivers. Specifically focused resources, supports and interventions developmentally-targeted to the needs of all young people aged 0-17 years are required.

For some infants, children and adolescents, the sequelae of family violence will lead to the development of mental illness requiring specialist, evidence-based treatment. In these scenarios, psychiatrists, and in particular those with advanced training in child and adolescent psychiatry, are uniquely placed to take a leadership role in developing and implementing therapeutic responses, both at the individual patient and systemic level. Psychiatrists, as medical doctors with specialisation in mental health, have unique insight into how family violence is a potent traumatogenic agent for children, with significantly deleterious physical and mental health consequences often continuing into adulthood.

The RANZCP consulted widely with its expert committees to formulate its response to the AHRC. This included extensive consultation with the Faculty of Child and Adolescent Psychiatry, a body of experts promoting the highest standard of clinical practice, training and research pertaining to child and adolescent psychiatry. The RANZCP's Community Collaboration Committee also provided important insights from the perspective of people with lived experience of mental illness, carers and psychiatrists with a strong focus on consumer and carer involvement and recovery-informed practice. The RANZCP Victoria Branch's Family Violence Working Group was also invaluable in informing the RANZCP's national response. This submission is a synthesis of specialist advice from these committees and other expert, clinically-informed and mental health-focussed perspectives.

Key recommendations

Family violence incurs a huge cost on children, families and society overall. In purely economic terms, the cost of family violence to the Australian economy each year is estimated to be $9.9 billion (Phillips & Vendenbroek, 2014). The RANZCP urges all stakeholders to invest in effective solutions and responses as the most cost effective and long term way of breaking the cycle of family violence.

- Medical practitioners and other professionals working directly with children and families must have better access to training on family violence so as to be better equipped to identify and respond.
- Psychiatrists and other professionals in direct contact with families and children must be trained to identify groups particularly at risk of family violence, including those with mental illness, Aboriginal and Torres Strait Islander peoples, CALD and particularly refugee and asylum seeker groups and pregnant women. Clinicians should apply particular vigilance when working with these populations in order to identify family violence as early as possible.
- Psychiatrists must bring an awareness of the continuing impact of the Stolen Generations on Aboriginal and Torres Strait Islander well-being and family dynamics. A full understanding of the role of complex trauma in Aboriginal and Torres Strait Islander presentations, and the cultural competency to respond and make referrals as appropriate is crucial.
- Family violence in CALD communities must be addressed in a culturally sensitive manner, free from assumptions about religious or cultural belief systems. Interpreters should always be used if there are language barriers to communication.
- Pregnancy is a time of heightened risk for mother and child. Doctors must ensure they screen women for family violence and be familiar with appropriate responses.
- Awareness of the unique mental health needs of infants and children should be promoted by being incorporated into the curricula of undergraduate and postgraduate medical training as well as continuing professional development (CPD) for practicing clinicians.
- Existing criteria for diagnosing mental health disorders in infants should be implemented in Australian healthcare systems.
- A full range of age-appropriate, evidence-based clinical interventions, such as trauma-informed CBT, must be readily available via the new Primary Health Networks.
- More trainee positions in both child and adolescent and perinatal and infant psychiatry are required.
- A full range of specialist support services that are accessible in the community should be available to support primary healthcare in the community.
- A comprehensive range of specialist services for children affected by family violence is required to address the needs of the most complex and severely affected, to reduce and prevent the adverse sequelae of intergenerational violence.
- Psychiatrists and psychiatry trainees working with parents should continue to develop skills and expertise to identify, provide early intervention, ensure recovery and prevent the adverse impacts of family violence on children.

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What are the definitional issue in relation to family and domestic violence affecting children?

Definition of family violence

Many different terms are used to describe violence between people in a close relationship, including intimate partner violence, family violence and domestic violence. Part of the complexity is in arriving at a term that adequately encapsulates the experience of traditional western family units, Aboriginal and Torres Strait Islander kinship groups, same sex attracted relationships, culturally and linguistically diverse (CALD) family groups and any other of the manifestations these relationships can take. For the purposes of this submission the RANZCP has elected to use the term family violence.

Definitions can also be complex and it is important to be clear and accurate about what family violence is. The RANZCP supports the definition of family violence recommended by the Australian Law Reform Commission and the NSW Law Reform Commission, as follows:

> Violent or threatening behaviour, or any other form of behaviour, that coerces or controls a family member or causes that family member to be fearful. Such behaviour may include but is not limited to: physical violence, sexual assault and other sexually abusive behaviour, economic abuse, emotional or psychological abuse, stalking, kidnapping or deprivation of liberty, damage to property, irrespective of whether the victim owns the property, causing injury or death to an animal irrespective of whether the victim owns the animal, behaviour by the person using the violence that causes a child to be exposed to the effects of behaviour referred to above (ALRC & NSWLRC, 2010).

As the above definition shows, family violence encapsulates a diverse array of behaviours, some of which can be subtle or difficult to pinpoint. There is a lack of awareness that restricting access to finances, constant phone calls or restricting time spent with friends and family, for example, may constitute family violence. This is an issue for survivors of family violence, who may not be aware of the supports available to them, as well as for medical practitioners and others who may miss opportunities for identifying family violence in patients/consumers.

For children the distinction between acceptable and unacceptable behaviours within the family unit can be particularly blurred. Children who have grown up in family violence contexts may not have accurate reference points for how healthy relationships function. It is important that children aged approximately eight years and above are able to access age-appropriate information outside of the family environment on respectful interactions, role modelling of boundaries and constructive conflict resolution, and what to do when they experience unacceptable behaviours. Children aged seven and under are not yet developmentally mature enough to grasp these complexities and require safety and protection from an adult first and foremost.

Family violence and child abuse

The distinction between family violence where a child is present and child abuse can also be complex. The definition of family violence above includes ‘behaviour by the person using the violence that causes a child to be exposed to the effects of behaviour referred to above’. In family violence situations children can be used to inflict additional suffering on the parent by allowing their children to witness acts of violence or using the threat of violence towards children as a tool of manipulation.

Exposure to family violence is also considered to be a form of child abuse in its own right. Even when the child does not directly witness family violence, maternal stress and the overall environment of fear is known to have deleterious impacts on the child’s mental health, with 80-90% of children estimated to suffer from vicarious trauma even if they do not witness the incident directly. Finally, presence of family violence in the child’s home is known to be a high risk factor in itself for other forms of child abuse,

including child abuse or neglect (RACGP, 2014). It is estimated that family violence is present in 55% of physical abuse cases and 40% of sexual abuse cases against children (Richards, 2011).

Recommendations

- Medical practitioners and other professionals working directly with children and families must have better access to training on family violence so as to be better equipped to identify and respond to risk factors.
- Infants and children require safety and protection from an adult first and foremost.

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?

Overall prevalence

It is estimated that in 2012 in Australia 17% of women and 5% of men experienced family violence and that much of this was witnessed by children in the home (ABS, 2012). Research indicates that children are disproportionately present in households with family violence and that young children, aged zero to five years of age are disproportionately represented among these children (Fantuzzo et al, 1997). It is reported that around half of the children who witness family violence witness severe forms, such physical violence involving weapons (Kowalenko, 2013).

Incidence of mental illness

Men and women with mental illness are at heightened risk of experiencing all types of violence during their lifetime, with men particularly vulnerable to violence from a stranger and women more vulnerable to family violence. Research conducted in the United Kingdom found that women with mental illness across all diagnoses were more likely to have experienced family violence in their adult lifetime, as follows:

- Women with depressive disorders were two and a half times more likely, with a 45.8% prevalence
- Women with anxiety disorders were three and a half times more likely, with a 27.6% prevalence
- Women with post-traumatic stress disorder (PTSD) were seven time more likely, with a 61% prevalence (Trevillion et al., 2012).

The linkages between mental ill health and family violence are complex and bidirectional. Social disadvantage, illness, adverse experiences and marginalisation can heighten vulnerability and stall recovery. More research is required to better understand the way mental illness is a risk factor for experiencing family violence and how experiencing family violence can lead to increased vulnerability to developing mental illness.

Children who have one or more caregiver with a mental illness are already at increased vulnerability of developing mental illness themselves and experiencing adverse effects through their caregiver's reduced emotional availability and capacity to provide support (RANZCP, 2009). It is estimated that up to one in five children in Australia have a primary caregiver with a mental illness (Reupert et al., 2012). Given the link between family violence and mental illness, this group of children are particularly at risk. They are often exposed to a 'triple whammy' of mental illness, family violence and drug and alcohol use, all of which poses a direct threat to their own wellbeing. Psychiatrists and other professionals who work

directly with children and family must bring an awareness of risk factors to their practice and be vigilant in detecting vulnerability.

Aboriginal and Torres Strait Islander communities

Another group vulnerable to disproportionately high levels of family violence is Aboriginal and Torres Strait Islander populations. Aboriginal and Torres Strait Islander women and children are amongst the most vulnerable to experiencing violence in Australia, including being 35 more likely to be hospitalised due to family violence related assaults compared with non-Indigenous Australian women and girls (COAG, 2010).

The high prevalence of family violence in Aboriginal and Torres Strait Islander communities is in large part linked to the damaging policies enforced by the government, including those that led to the Stolen Generations. Forced removal of children from their families and of communities from their land has contributed to the intergenerational trauma that Aboriginal and Torres Strait Islander peoples must continue to grapple with. Policies such as the Stolen Generations have created deep spiritual, emotional and psychological damage which has contributed to the lower than average health outcomes, high levels of incarceration, problematic substance use, mental health issues and mortality in Aboriginal and Torres Strait Islander populations. The trauma incurred by the policies leading to the Stolen Generations has also led to whole of community and intergenerational complexity when it comes to the capacity of primary caregivers to form healthy attachment relationships with their dependents, given their own experiences as children (RANZCP, 2011). This complex set of factors can lead to heightened vulnerability to family violence. Historically negative experiences of Social Services, the police and Child Protection also means that Aboriginal and Torres Strait Islander peoples may be more reluctant to report family violence and seek assistance due to fear that it will lead to family separation and action being taken without consultation.

When addressing family violence in Aboriginal and Torres Strait Islander communities, psychiatrists and other professionals must ensure a culturally appropriate and complex trauma-informed approach. Practitioners are encouraged to consult with appropriate Aboriginal and Torres Strait Islander services for advice if necessary, taking care to uphold the privacy of consumers.

Culturally and linguistically diverse communities

Culturally and linguistically diverse (CALD) communities are another particularly vulnerable group. There is a lack of research available to quantify the prevalence of family violence in diaspora groups in Australia, however the few that exist indicate that rates are similar to those in the home country. In Australia one third of the migrant community come from South East Asia, where it is estimated that the lifetime prevalence rate of family violence is 41.7% (RACGP, 2014).

In CALD communities, the woman's experience of family violence must often be understood in relation to the acute and prolonged stressors of war, loss and displacement. Relocation to a foreign country with unfamiliar customs can also have a disruptive effect on traditional gender roles, which can in turn lead to an increase in the incidence of family violence. In Australia women from some cultures may have access to freedoms that were not available to them in their home country, such as work, education and increased freedom of movement. This can be disruptive to the family dynamic as each member grapples with their new roles and place in the community. Research has shown that family violence can sometimes increase in these instances, as male family members struggle to realign their identity and adapt to their adopted home (Zannettino, 2012).

Refugee and asylum seeker groups are especially vulnerable, as family violence is known to increase in countries where war or other conflict or social upheaval has recently taken place (RACGP, 2014). Children from refugee or asylum seeker backgrounds may have witnessed or experienced serious

violence prior to their arrival in Australia. Continuing violence at home can add to the pre-migration trauma experiences and the acculturative stress issues (RACGP, 2014).

Addressing family violence in CALD communities must be approached with cultural sensitivity and through an interpreter whenever necessary. Psychiatrists and other professionals must avoid making assumptions about a patient's cultural and religious beliefs. CALD communities may experience many barriers to disclosure, including social isolation, fear about impacts on visas and lack of knowledge about available services.

Pregnant women

Pregnancy is another known risk factor in family violence, with the potential for very serious impacts on foetal development, birth and child outcomes. In an Australian survey of 400 pregnant women, 20% had experienced violence during their pregnancy (Walsh, 2008). A meta-analysis of eight studies found that women who reported physical, sexual or emotional abuse during pregnancy found that they were 30% more likely than women who had not experienced abuse to give birth to a baby with a low birth weight (Murphy et al., 2001). It has been noted that health risks associated with family violence, such as stress, smoking, poor weight gain, drug and alcohol use, are both risk markers and consequences of violence (Taft, 2002). All these factors will contribute to the likelihood of a poor birth outcome, particularly low birth weight, with ongoing implications for the health of the child.

Recommendations

- Psychiatrists and other professionals in direct contact with families and children must be trained to identify groups particularly at risk of family violence, including those with mental illness, Aboriginal and Torres Strait Islander peoples, CALD and particularly refugee and asylum seeker groups and pregnant women. Clinicians should apply particular vigilance when working with these populations in order to identify family violence as early as possible.
- Psychiatrists must bring an awareness of the continuing impact of the Stolen Generations on Aboriginal and Torres Strait Islander well-being and family dynamics. A full understanding of the role of complex trauma in Aboriginal and Torres Strait Islander presentations, and the cultural competency to respond and make referrals as appropriate is crucial.
- Family violence in CALD communities must be addressed in a culturally sensitive manner, free from assumptions about religious or cultural belief systems. Interpreters should always be used if there are language barriers to communication.
- Pregnancy is a time of heightened risk for mother and child. Doctors must ensure they screen women for family violence and be familiar with appropriate responses as appropriate.

What are the impacts on children of family and domestic violence?

Mental health impacts during infancy and early childhood

Historically the mental health of young children has been largely overlooked, with focus on assessment and treatment of mental illness only commencing when the child reaches adolescence or adulthood. A 'wait and see' approach was taken to behavioural problems in infancy. This issue was confounded by the relative paucity of infant and early childhood mental health materials in undergraduate and postgraduate curricula for medical students training to be psychiatrists and CPD for practicing clinicians (Osofsky &Lieberman, 2011).

It is now understood that infants have an extensive array of biopsychosocial competencies and are able to react to the meaning of others' intentions and emotions (Tronick & Beeghly, 2011). Early childhood is in fact the period of greatest vulnerability to stress-related changes to the brain. The majority of neurological development associated with language, values and complex cognitive and emotional functioning are determined in these early years of life. Infants who experience extremes of abuse or neglect are at risk of failure to thrive, reduced brain size, impaired development and ongoing mental health issues.

Children's' development is embedded in family dynamics and the social environment, and is deeply affected by parental mental health and stress (Nelson & Mann, 2011). An infant's sense of self and wellbeing is enveloped within that of their mother's. Young children are very much attuned to maternal depression, and can experience threat to the life of their mother as akin to a threat to their own life. When the family is a dangerous rather than protective environment the child does not have a buffer from their fear. The family becomes a potent traumatic insult, with ongoing ramifications for the health development of the infant (RANZCP, 2014).

Infants who are exposed to family violence will be exposed to dysfunctional relationships, inconsistent attachment dynamics and interactions characterised by negative affect and inconsistent meaning-making. These factors can have significant implications for the way infants make sense of the world around them and develop the core sense of themselves. Infants as young as four months old who have been exposed to these environments have been found to engage in more negative patterns of interaction with other sensitive adults and explore the inanimate environment less avidly (Tronick & Beeghly, 2011).

Maternal depression is a common outcome of family violence and one which the child is very attuned to. Women suffering from depression can experience barriers to forming healthy attachment bonds with their children. Attachment refers to the genetically predisposed tendency for young children to seek comfort, support, nurturing and protection from at least one primary caregiver. Nurturing and consistent care is essential during infancy when the child begins to form and require attachment relationships (Zeanah et al., 2011). Insecure attachment, particularly during the first three years of life, can disrupt the healthy development of rudimentary neuronal pathways and has the potential to lead to ongoing problems.

The RANZCP's Faculty of Child and Adolescent Psychiatry and the RANZCP's Special Interest Group in Perinatal and Infant Psychiatry are at the forefront of building a more evidence-based and clinically informed infant, child and adolescent mental health workforce. Whilst significant steps have been taken towards developing a system more responsive to the mental health needs of young children, much more work is still required.

One important step forward is to develop reliable and valid criteria for identifying and assessing mental health symptoms and disorders in early childhood. Young children undergo rapid developmental changes, have limited language and have a unique interdependence with their caregivers (Egger & Emde, 2011). This increases the complexity of developing diagnostic criteria for this age group, as well as the importance of doing so. Improvements to the availability of evidence-based therapeutic interventions for infants and their caregivers is also essential. Infancy is a time of heightened susceptibility to the negative impacts of trauma, but it is also a period of openness to the possibility of rewriting meanings and forging new connections for both infant and caregiver (Tronick & Beeghly, 2011).

Mental health impacts during childhood and adolescence

Epidemiological data shows that half of all mental disorders begin by age 14. Adverse childhood experiences (ACE), including family violence, are known to be highly co-occurring and strongly associated with the onset of psychiatric disorders (Haliburn, 2014). Insecure attachment during infancy,

as described above, can manifest as conduct disorder, aggression, anxiety and mood disorders, hyperactivity, antisocial behaviour, vulnerability to stress, difficulty regulating negative emotions, learning problems and displays of hostility or oppositional behaviour as the infant moves through childhood (RANZCP, 2014). These can lead to self-harm, substance use, homelessness and depression in adolescence, with ongoing implications (Kowalenko, 2013).

Children exposed to trauma can develop behavioural difficulties associated with the unpredictability of their world leading to a lack of verbal and conceptual understanding of their inner world and their surroundings and how these interact. These children may experience other people as sources of terror or gratification, but rarely as fellow human beings and potential allies, and tend to have problems in social settings (Streeck-Fischer & Van Der Kolk, 2000). These difficulties can mean that the child will be more difficult to parent, which in turn creates an additional layer of stress and interfamilial tension, which can in itself amplify the trauma experienced by the young person.

One study of young people admitted into mental health inpatient units found that 77% of the 710 children who had engaged in deliberate self-harm reported difficulties in relationships with family members (de Kloet et al, 2011). Exposure to family violence is also linked to higher rates of physical health problems in children, such as increased incidence and severity of childhood asthma (Kowalenko, 2013).

Whilst the above demonstrates that the impacts of family violence on the physical health and emotional wellbeing of infants, children and adolescents can be significant, it is important to remember that they are not set. Whilst family violence incurs a high mental health cost on many young people, about one third of children who experience family violence do not show obvious signs of trauma. Children's ability to cope in violent homes is largely linked to their mother's ability to maintain consistent care, model assertive and non-violent responses to abuse, maintain high levels of extended familial and social support and sustain their well-being (Kowalenko, 2013). This reinforces the importance of making evidence-based therapeutic interventions available at the earliest possible juncture for children and parents.

Impacts during adulthood and across generations

(CDCP, 2014)

The above diagram demonstrates how ACEs, which include exposure to family violence, can have whole of life impacts, including leading to poor quality of life, illness and death (CDCP, 2014). There is increasing evidence to suggest that trauma early in life can lead to psychotic illness and other psychiatric disorders, though more research is required in this area (Van Os, 2014). It is also being found that

depressed adults respond to pharmacotherapy differently depending on whether they experienced childhood trauma or not (Haliburn, 2014).

The neurological impacts of early childhood trauma and insecure attachment can also provide some clues as to how family violence can become intergenerational. As discussed above, children whose formative years are affected by heightened and sustained stress and fear are vulnerable to developing long term mental health issues, which is in itself a risk factor for both experiencing and perpetrating family violence.

Further, experience of developmentally appropriate attachment and boundaries in childhood is an important part of learning how to develop healthy relationships later in life. For some children who may otherwise love and respect their father, seeing him perpetrating violence can be confusing and they may come to consider violence as a legitimate response. These children can be at risk of developing psychologically controlling, physically violent or sexually abusive behaviours in adulthood and potentially, as a father and partner, repeat the family violence they witnessed as a child.

Psychiatric classification

Despite the amount of evidence that speaks to the complexity of the relationship between mental health and family violence, there is a lack of satisfactory nosology for family violence in psychiatric classifications. This is a barrier to teaching students and clinicians about family violence issues. There is a growing understanding of the need to address this, and the *Diagnostic and Statistical Manual of Mental Disorders* 5th Edition (DSM-5) has included family violence for the first time under 'Other conditions that may be a focus of clinical attention' in the chapter 'Relational problems' (APA, 2013).

PTSD is the most common clinical manifestation of family violence in children that meets diagnostic criteria. It is under-recognised in practice in primary care and in specialist care (McGilvary, 2013).

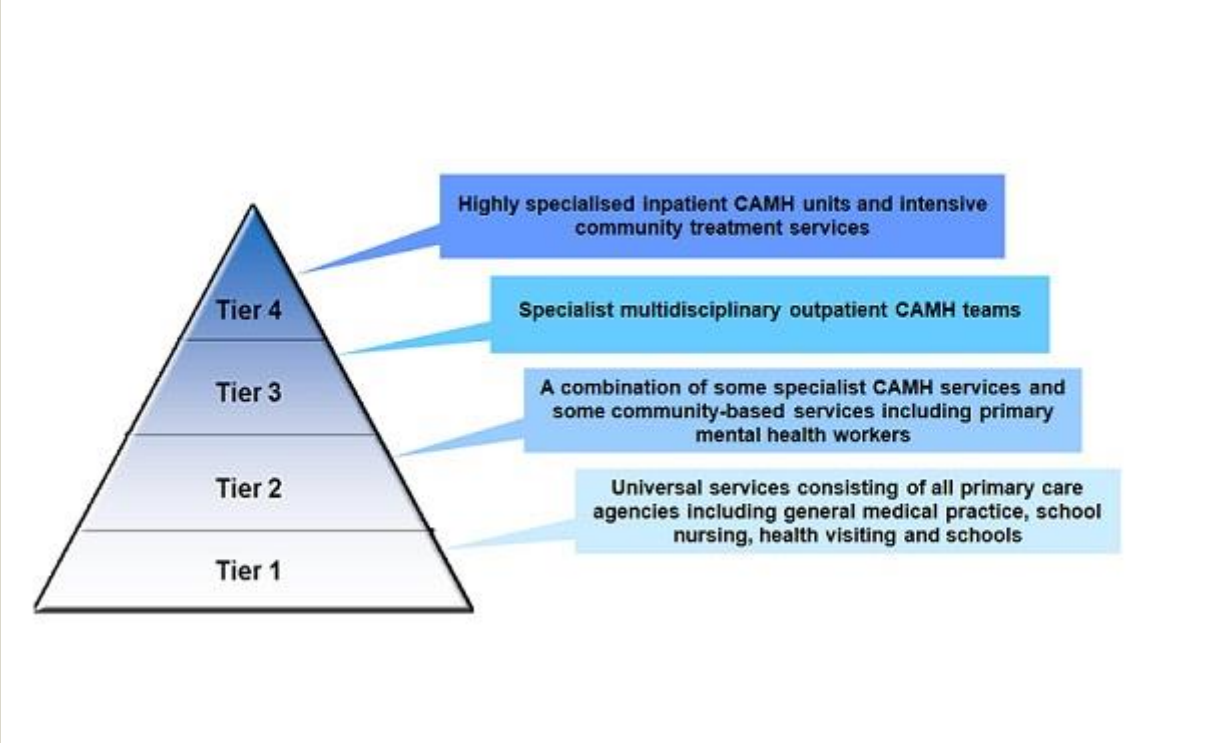
Recommendations

- Awareness of the unique mental health needs of infants and children should be promoted by being incorporated into the curricula of undergraduate and postgraduate medical training as well as CPD for practicing clinicians.
- Existing criteria for diagnosing mental health disorders in young children requires consistent implementation in health service data systems.
- A full range of age-appropriate, evidence-based clinical interventions, such as trauma-informed CBT, must be readily available so that they can be readily accessed in the community.
- Psychiatrists and other clinicians must be attuned to identifying the range of behaviours that may indicate childhood trauma and to respond appropriately.
- A classificatory system specific to family violence could be developed and would enable specific training for students and clinicians on this topic.
- Health informatics developments could more readily inform the impact of family violence on all family members.
- Epidemiological studies of children affected by family violence and their access to services should be a strategic priority for research funding by institutions such as the National Health and Medical Research Council (NHMRC).

What are the outcomes for children engaging with services, programs and support?

Mental health outcomes of accessing support

For many children who have experienced family violence, support and treatment from universal primary care services such as general practitioners and school programs will be enough to address the sequelae of trauma. For other young people, mental health outcomes may be more deleterious and a combination of some child and adolescent mental health specialist services (CAMHS) and some community-based services will be necessary. For young people who develop particularly acute mental ill health as a result of the trauma they have experienced, highly specialist inpatient units and intensive community treatment services led by specialist child and adolescent psychiatrists, and perinatal and infant psychiatrists are necessary. The breakdown these services is illustrated below:



(NHS, 2015)

Children who have experienced family violence but are engaging with evidence-based therapeutic services, programs and support have far better mental health outcomes than those who are not. However, it can be difficult for programs to make contact with children if their caregiver is not engaging in supports, particularly when programs require the consent or involvement of a caregiver. Children face multiple barriers to asking for help independently, including fear that they will not be believed, assuming the abuse is normal, wishing to protect the perpetrator, being threatened with reprisals if they tell, experiencing disbelief and confusion about what is happening to them, lack of linguistic ability to describe what is happening or a feeling of being responsible (RACGP, 2014).

Child psychiatrists often treat those who suffer with clinical syndromes, such as PTSD, which have developed in the context of experiencing family violence. Clinicians who work directly with children and their families have an important role in identifying family violence and responding appropriately. Until recently, health professionals have overall not engaged with the issue of family violence, leading to many missed opportunities for early detection and intervention. Clinicians have reported that they did not believe that enquiring about family violence was a part of their role or within their competence (Rose, 2012).

Healthcare providers are often the first professional contact that survivors of family violence have, so it is essential that clinicians are better supported to develop skills in this area (WHO, 2013). Research in the United Kingdom found that general practitioners who received training and support in implementing a family violence intervention program had, one year later, made referrals to appropriate family violence services at a rate 22 times higher than a control group who had not receive the training (Devine et al, 2012). These figures are illustrative of the potential the medical profession has to provide essential early intervention and support to children and families experiencing family violence.

The RANZCP emphasises that whilst training medical practitioners to screen for and identify family violence is essential, it is just as important to address this holistically. Screening for family violence will likely lead to a spike in the numbers of families who require support services, and at present there may not be the resources available to meet the level of increase need. Clinical specialist services including child and adolescent psychiatry and perinatal and infant psychiatry, in public and private practice, requires expansion to be able to respond appropriately.

Identifying family violence

In assessing the impact of family violence on children it is an essential component of healthcare practice to assess the child's experience and perspectives so that parent report is not the sole basis for assessing children's functioning, responses, conditioning or coping.

Identifying children who are experiencing family violence can be complex and requires sensitivity and care. It is essential that children are not assessed as 'little adults', but rather the clinician's approach should be age-appropriate and nuanced. The RANZCP overall considers using the language of family violence and the format of screening questions with young children to be inappropriate.

Emphasis should rather be placed on obtaining the child's perspective on how their parents relate to one another and what their home environment is, in a less formulaic way. Child psychiatrists will often have the opportunity to make follow up sessions with children. In these scenarios clinicians should not necessarily expect a disclosure straight away, and may need to build trust over several sessions before the child is ready to open up about their experience of family violence. The child may express their experiences in a diversity of manners, including through actions, play or drawings. Behavioural manifestations of trauma are also common. Medical practitioners must remain open to the child's preferred manner of expression and be receptive to the meaning they are communicating.

It is important to note that if the child is found to be at risk, mandatory reporting is required as a matter of law. Medical practitioners are encouraged to seek external assistance from an appropriate service if they are unsure.

Mental health interventions for children experiencing family violence

A range of evidence-based child-parent psychotherapeutic interventions are available to treat traumatised young children and their families. Some are specifically designed for children subjected to family violence (Bunstone & Heynatz, 2006; Lieberman et al., 2005). Despite coming from a range of theoretical backgrounds, almost all of these interventions involve working to achieve safety within relationships, providing psychoeducation, treating the effects of trauma and then developing healthy behavioural, emotional and relationship functioning.

These evidence-based interventions can work across a spectrum, from early intervention with asymptomatic children exposed to recent violence through to complex interventions in children with high levels of traumatic symptoms and dysfunctions in complex family situations. Some work has been done adapting interventions to families caught in conflicted family court disputes. Interventions have also been developed for children in the context of Child Protection services. Of particular note is trauma-focussed

CBT, which has a strong evidence base for treating children with PTSD as young as three years of age (Scheeringa et al, 2011).

The Australian Government Department of Health's Access to Allied Psychological Services (ATAPS) and the Better Access initiatives can link children with these evidence-based therapeutic interventions if community access is fostered, led by CAMHS.

Holistic approach

Ultimately, children who have experienced family violence require interventions and programs designed to make them safe, to heal and to grow. The solution cannot lie with the child, however. To curb family violence the child's mother must have access to holistic services to support the family to access safe accommodation, counselling, education, employment and negotiate the court system. The importance of securing these things cannot be overstated in supporting families to rebuild and recover.

Recommendations

- Family violence must be better incorporated into undergraduate, postgraduate and CPD curricula.
- A more appropriate classificatory system for family violence is required, so that it can be systematically integrated into training and practice.
- Screening and assessing for experience of family violence in children should be undertaken in an age appropriate and nuanced manner, and their perspective and lived experienced delineated.
- Children who are exhibiting trauma should be referred to clinicians skilled in delivering evidence-based psychotherapeutic interventions such as trauma-focussed CBT.
- Approaches to family violence must be holistic. Children require specifically tailored therapeutic interventions, however they also require safety, stability and healing for their family unit. This often requires coordination, case management and care planning to best integrate the range of health, education, legal, accommodation, welfare and other agencies to facilitate recovery.

What are the outcomes for children of public policy approaches and educational campaigns targeting family and domestic violence?

Mental health policy

Early life trauma causes brain changes, with resultant changes in neurophysiology and behaviour which can have lifelong and even intergenerational impacts (Haliburn, 2014). Approaches to health policy in Australia must ensure the mental health care needs of infants, children and young people are adequately incorporated via ATAPS, Better Access and CAMHS in general. The healthcare costs alone of unresolved childhood trauma in Australia is $9 billion (Kezelman et al., 2015). Investing in the public health issue of family violence and childhood trauma would lead to long-term savings and a healthier population going forward.

At present there is a general paucity of specialist services and professionals to assess and treat more severe developmental issues in infants, such as can be created by exposure to family violence. Although the Commonwealth Government's Specialist Training Program (STP) provides crucial funding for additional Trainee positions in child and adolescent psychiatry as well as perinatal and infant psychiatry, more training positions are needed to address this shortage.

Interagency collaboration is also essential to support and promote healthy development and to address psychological problems in children and adolescents. Osofsky and Lieberman describe a systems-of-care approach with five critical components: financing, policy, training, service delivery and system collaboration. The service systems drawn into these systems of care would include judicial, legal, child welfare, mental health, health care, child care, early intervention systems and family resource centres (Osofsky & Lieberman, 2011). The focus would be on ensuring that children and families receive consistent, timely and appropriate referrals, follow up and support. Assessment and early intervention would lead to appropriate treatment at the earliest possible juncture. The importance of collaboration is increasingly being recognised, with mechanisms for cross-sector collaboration such as Risk Assessment Management Panels (RAMPs) being established to enable the family court, police and schools, for example, to communicate (Plunkett, 2014). It is essential that medical and mental health professionals are included in such approaches to decision-making.

Recommendations

- Approaches to health policy must ensure the mental health needs of infants and children are understood and incorporated.
- More trainee positions in child and adolescent psychiatry and perinatal and infant psychiatry are required.
- Expand access to trauma-informed CBT and other evidence-based therapies for 0-11 year olds through allied psychological services via the Primary Health Networks.
- Interagency collaboration is key, and mechanisms to support effective systems of care, such as RAMPs, should be supported and implemented. Psychiatrists have a key leadership role in ensuring a mental health and trauma-informed approach is applied to these collaborations.

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

Research priorities

In order to better inform policy direction and treatment of children affected by family violence, more research is required in the following areas:

- Epidemiology of children affected by family violence
- Access to appropriate levels of care, including specialist care
- Levels of impairment
- Effects on educational achievement
- Outcomes for social functioning and development
- Impact of family violence on the aetiology of clinical syndromes in children and adolescents
- Legislation to ensure support and care needs of children are appropriately addressed at an adequate standard to improve child outcomes and break the cycle of intergenerational violence
- The relationship between trauma and mental illness
- The relationship between childhood trauma and response to pharmacotherapy later in life (Haliburn, 2014)
- Improving mental health legislation so that adverse family factors such as family violence and the impact on children, particularly in the context of parental mental illness, is consistently identified and support plans are required.

Recommendation

- More research into the above points is required so as to ensure that mental health treatments for children who have experienced family violence is informed by a strong evidence base and policy can be shaped to reflect the needs of this highly vulnerable population.
- Research funding organisations, for example the NHMRC, should prioritise and fund strategic research on children affected by family violence. This should address epidemiological studies, early intervention and treatment studies and the impact of public policy approaches, such as routine screening for parents and children on detection, access to intervention and child outcomes.
- Resilience should be investigated in those children exposed to family violence as a potential source of evidence to inform health promotion and child protection initiatives.

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