Australian Government

Australian Institute of Family Studies

Office of the Director
Telephone: +61 3 9214 7807

29 May 2015

Ms Megan Mitchell
National Children's Commissioner
Australian Human Rights Commission
GPO Box 5218
SYDNEY NSW 2001

Email: kids@humanrights.gov.au

Dear Ms Mitchell,

Re: Examination of children affected by family and domestic violence

The Australian Institute of Family Studies has conducted a significant amount of research of relevance to the Commission's Inquiry. This research includes large scale-quantitative studies of separated families and studies of service system responses to family violence. The main points of this research are summarised in the attached submission. In addition, we have provided information about other resources that may be of assistance as Appendix A to the submission.

I trust this information assists. However if we can provide further information or advice please do not hesitate to make contact.

Yours sincerely,

Professor Alan Hayes AM
Director

Attachment: AIFS Submission

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

Australian Government

Australian Institute of Family Studies

National Children's Commissioner

Examination of children affected by family and domestic violence

Submission from the
Australian Institute of Family Studies (AIFS) and
Australia's National Research Organisation for Women's Safety Ltd. (ANROWS)

Prepared by:
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Authorised by:
Professor Alan Hayes AM, Director AIFS,
and Heather Nancarrow, CEO ANROWS

29 May 2015

Introduction

This submission is based on research conducted by the Australian Institute of Families Studies (AIFS). Australia's National Research Organisation for Women's Safety (ANROWS; see Appendix for an explanation of ANROWS and its mission) is also providing preliminary information on its funded research currently being undertaken on the project "Domestic and family violence and parenting: mixed method insights into impact and support needs", by the Parenting and Abuse and Control Tactics (PACTs) team at AIFS.[1]

This submission primarily addresses Inquiry questions 2–6. The AIFS contribution draws on information from three key relevant reports[2]:

- 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 (LSSF Wave 3 Report); and[4]
- 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 (Domestic and Family Violence [DFV] Children Report).[5]

The Longitudinal Study of Separated Families (LSSF) Wave 3 (based on 9,028 separated parents, with interviews taking place in September–November 2012) and the Survey of Recently Separated Parents (SRSP) 2012 (based on 6,119 parents, interviewed in August and September 2012) provide more detailed empirical evidence on the prevalence, frequency and impact of family violence among separated parents, including whether children have witnessed the violence, than has previously been available. Both studies are based on samples derived from the same administrative dataset, now managed by the Department of Human Services—Child Support (DHS–CS).

The DFV Children Report involved a review and synthesis of the literature on the impacts of DFV on children aged 0–8 years. It also considered the evidence for, and best practice approaches to, primary prevention and early intervention strategies for children aged 0–8 years affected by DFV.

ANROWS would like to provide the National Children's Commissioner with further details of its funded research project "Domestic and family violence and parenting: Mixed method insights into impact and support needs", being led by the PACTs team at AIFS. This project is based on the premise that the impact of DFV on parenting capacity is poorly understood and that, to date, there is

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1. The PACTs team comprises Dr Rae Kaspiew, Dr Lixia Qu in collaboration with Professor Jan Nicholson, Professor Angela Taft, Ms Leesa Hooker (Judith Lunley Centre, La Trobe University) and Professor Cathy Humphries (University Melbourne).
2. 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 Women NSW) that funded the research referred to in the submissions.
3. This report was commissioned by the Attorney-General's Department (AGD) and provides benchmark data for the Evaluation of the 2012 Family Violence Amendments. The evaluation reports are due to be provided to the AGD on 30 August 2015. The SRSP 2012 report is available at: <www.ag.gov.au/FamiliesAndMarriage/Families/FamilyLawSystem/Pages/Familylawpublications.aspx>).
4. The first two waves of the Longitudinal Study of Separated Families (LSSF) were commissioned by the AGD and the then Department of Families, Housing, Community Services and Indigenous Affairs (now the Department of Social Services [DSS]), while the AGD commissioned the third LSSF wave: <www.ag.gov.au/Publications/Pages/Post-SeparationParentingPropertyAndRelationshipDynamicsAfterFiveYears.aspx>. The first wave findings fed into the *Evaluation of the 2006 Family Law Reforms* (Kaspiew et al., 2009).
5. This report was commissioned by NSW Women: <www.women.nsw.gov.au/violence_prevention/violence_prevention_studies>.

limited evidence internationally regarding the parenting capacity of both the victims and perpetrators of DFV. The evidence base in Australia on this question is under-developed. This project focuses on the impact of DFV on parenting. The aim of this project is to improve understanding of how DFV affects parenting capacity to reduce the negative impact of DFV on women and children. Specifically, it addresses three key questions:

1. How does a reported history of DFV affect mother–child and father–child relationships?
2. How do mothers who have experienced DFV perceive it has affected their relationship with their children?
3. To what extent have these mothers had contact with relevant services, and was this contact helpful or unhelpful?

The results of this project will provide an important foundation on which to base policy and practice strategies that respond to the needs of mothers and children whose relationships have been impaired through exposure to DFV. The research has three complementary strands. A literature review will describe and analyse the current state of empirical knowledge on the impact of DFV on the parenting and parent–child relationships of mothers, fathers and their children, in addition to identifying what strategies and programs currently exist for ameliorating these impacts. The methodology recognises that DFV has direct and indirect influences on parenting capacity.

A second quantitative element will generate primary evidence using three existing, large-scale databases: the Longitudinal Study of Australian Children (LSAC), the LSSF and the SRSP 2012. A series of new analyses will examine how experiencing DFV affects the capacity of men and women to be effective fathers and mothers and the consequences of DFV for the quality of the mother–child and father–child relationship and child wellbeing. This element will provide rigorous, quantitative evidence based on representative samples of separated (LSSF, SRSP) families and all families, including those who have separated (LSAC).

The third, qualitative, element will provide in-depth insight into the experiences of mothers who have used services across a range of areas (family law, child protection and DFV support) in the context of a history of DFV. The focus of this element will be twofold: the experience of mothering in the context of DFV and the experience of engaging with agencies and services against this background.

ANROWS believes that this project has national relevance through the use of national datasets and by examining the experiences of women across at least two states (Victoria and South Australia). It will generate new evidence directly relevant to policy and practice across the areas of child protection, family law, DFV and family support services. Across these sectors, the way DFV and its impact on mothering, fathering and child wellbeing are understood and responded to are varied and potentially conflicting. Our multidisciplinary team will draw on expertise in social work, socio-legal research, health research and population-based family studies to develop a common evidence base that will be credible and applicable across these areas. This project will produce three written deliverables, including a state-of-knowledge (literature review) paper due to be released in late 2015 and a final project report and a short-research-to-practice report, due to be released in late 2016. All written deliverables will be available on the ANROWS website upon release.

What do we know about the prevalence and incidence of DFV affecting children, and who is involved?

The LSSF and SRSP findings show consistent levels of family violence 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).[6] The LSSF Wave 1 data show that just under 60% of parents reported a

[6] De Maio et al. (2013) applied a similar methodology with a more detailed focus on family violence. Subtle differences in sample selection for the LSSF and the SRSP 2012 resulted in slightly different sample profiles as far as parents who had

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, the SRSP 2012 demonstrates that 64% of the sample reported pre-separation violence. These parents separated in 2011. The SRSP 2012 establishes considerable variability in the experience of family violence, reflecting a continuum of severity, through its analysis of the intensity with which various types of emotional abuse are reported (De Maio et al., 2013, pp. 28–29). This analysis shows that across five possible ranges, 18% of parents fell into a low intensity range and 13% fell into the two 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. 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 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 18% and 15% of parents reported safety concerns for themselves and/or their child as a result of ongoing contact with the other parent, and for 5% these concerns persisted across the three waves (Qu et al., 2014, pp. 32-33). In SRSP 2012, 17% of parents reported 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 children had seen or heard the violence (De Maio et al., 2013, p. 37).

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

Insights from the AIFS DFV Children Report

The AIFS DFV Children Report found that research over the last 20 years has unequivocally determined that children aged 0–8 years exposed to violence in the home suffer a wide range of poor psychosocial and health outcomes The literature indicates that exposure to DFV in childhood is associated with depression, anxiety, trauma symptoms, aggression, lower social competence, low self-esteem, fear and loneliness (Bedi & Goddard, 2007; Heugten & Wilson, 2008; Holt, Buckley & Whelan, 2008; Howell, 2011; Jaffe, Wolfe, & Campbell, 2012; Klitzman, Gaylord, Holt, & Kenny, 2003; Margolin & Vickerman, 2011; Spilsbury et al., 2008). Children exposed to DFV in childhood may also have poorer academic outcomes, higher rates of peer conflict and impaired cognitive functioning (Klitzman et al., 2003; Tuyen & Larsen, 2012). Health and socio-economic impacts include higher likelihood of future alcohol and drug abuse, depression, unemployment and homelessness (Ellonen, Piispa, Peltonen, & Oranen, 2013; Yates, 2012).

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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).

However, there are considerable divergences in outcomes and impacts in different populations of children (Holt et al., 2008) and resilience in children is not well understood. The literature suggests that there are several factors that may mitigate children's exposure to violence, including the extent of children's peer and social support; their relationship with mother or other primary caregiver; whether the violence was ongoing or short-term; age of child when the DFV occurred; and whether children received an adequate response/treatment following the DFV (Gewirtz & Edeslon, 2007; Heugten & Wilson, 2008; Holt et al., 2008; Howell, 2011; Humphreys & Houghton, 2008; Martinez-Torteya, Bogat, von Eye, Levendosky, 2009; Richards, 2011).

Several authors suggest that studies assessing the impact of children's exposure to violence may be fraught with methodological problems and urge caution in drawing cause-and-effect assumptions regarding children's exposure (Chan & Yeung, 2009; DeBoard-Lucas & Grych, 2011; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Heugten & Wilson, 2008). The literature suggests that children's exposure to DFV occurs within what DeBoard-Lucas and Grych (2011) called a "constellation of risk" and disadvantage. That is, DFV often occurs alongside a host of other risk factors, such as parental substance abuse, poverty, family dysfunction, other forms of child abuse and neglect, mental ill-health, and social isolation (Bromfield, Lamont, Parker, & Horsfell, 2010; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Higgins, 2004; Moylan et al., 2010). It is consequently difficult to separate the effects of these factors from the effects of exposure to DFV. As Holt et al. (2008, p. 803) highlighted, "the presence of multiple stressors in a child's life may both elevate the risk of negative outcomes and possibly render indistinct the exact relationship between domestic violence and those negative outcomes".

Impacts of family and domestic violence on children based on the SRSP 2012

This discussion is based on the SRSP 2012, which examined connections between children's wellbeing and family violence.[7] Firstly, we deal with children's wellbeing when differing types of family violence had occurred before/during and since separation. Secondly, if there was family violence, we investigated whether children who witnessed it differed from those who did not. As the same person reported on both the occurrence of violence and children's wellbeing, some "eye of the beholder" effects (where the reporter's knowledge of the family violence may have influenced their assessment of the child's wellbeing) are likely to have contributed to the findings next reported. However, the size and consistency of differences suggest that the patterns also reflect genuine divergences in children's wellbeing.

When family violence occurs alongside a relationship breakdown, there can be a compounding effect upon child and parent wellbeing, both immediately and in the long term. One of the aims of the SRSP 2012 was to shed light on this issue. However, it is not possible to draw conclusions about causality from these data (i.e., that family violence *leads to* lowered wellbeing). Nevertheless, we can observe whether rates of wellbeing diminish when parental separation and family violence co-occur.

The assessments of child wellbeing are based on parents' assessments of children's physical health, satisfaction with overall child wellbeing, behavioural problems (children 1–3 years, using the Brief Infant-Toddler Social and Emotional Assessment (BITSEA) (Briggs-Gown & Carter, 2006).

Children's wellbeing and family violence before/during or since separation

Level of physical health

Looking first at children's physical health, while in general a large majority of children were reported as being in excellent or very good health, rates were higher when there had been no violence, compared to when violence had occurred (Figure 1). Fathers' and mothers' reports differed slightly: according to fathers, children had poorer health when physical violence was reported and slightly better health when emotional abuse alone was experienced, whereas health rates were reported to be

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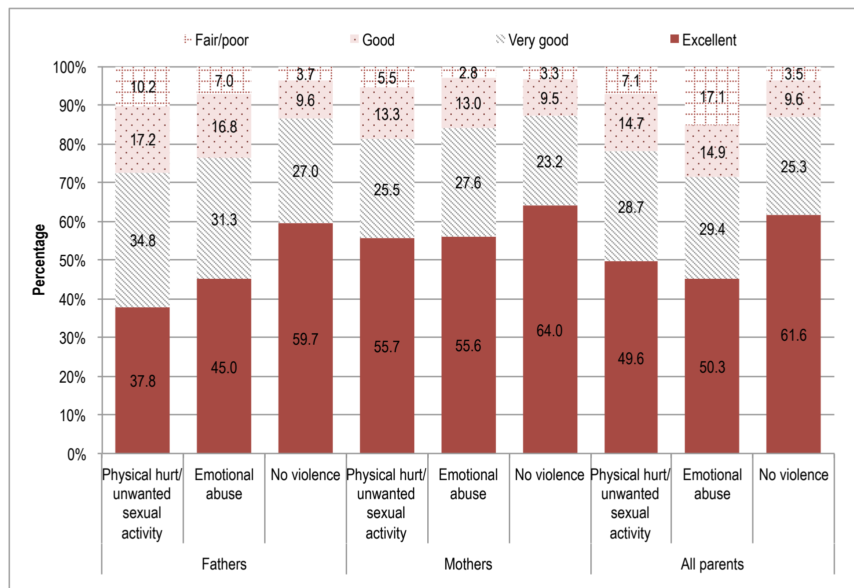
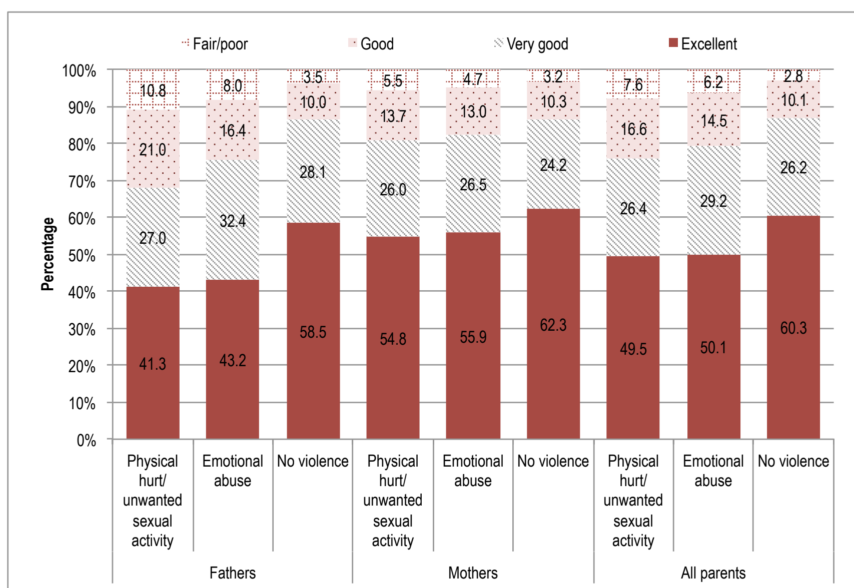
7 This section substantially reproduces section 7.2 in the SRSP report (De Maio et al., 2013), authored by Diana Smart.

similar across the two types of violence by mothers. The patterns were the same for children in differing age bands (0–2, 3–4, 5–11, 12–14 and 15–17 years; not shown). Similarly, for the period since separation, children tended to have better health when there had been no violence, compared to when either type of family violence had occurred (Figure 2).



Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Figure 1: Perceptions of focus child's physical health, by parents' experiences of family violence *before/during* separation, father and mother reports



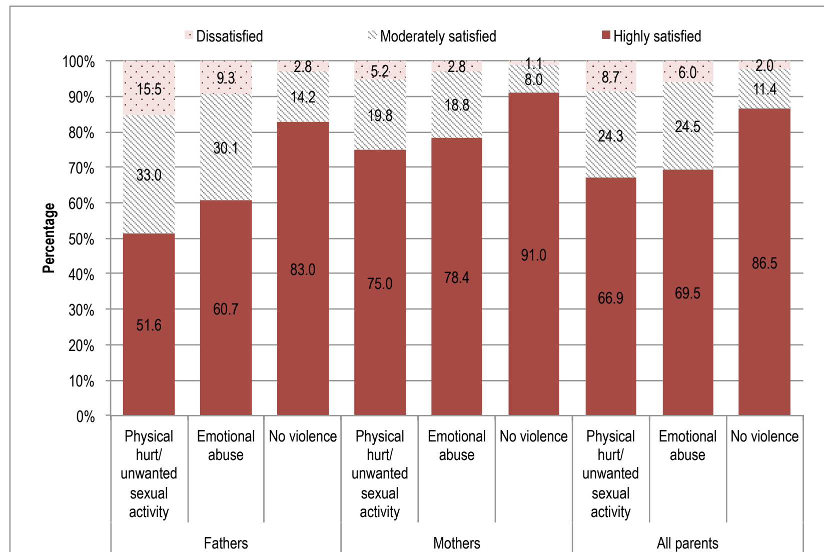
Note: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Figure 2: Perceptions of focus child's physical health, by parents' experiences of family violence *since* separation, father and mother reports

Satisfaction with overall child wellbeing

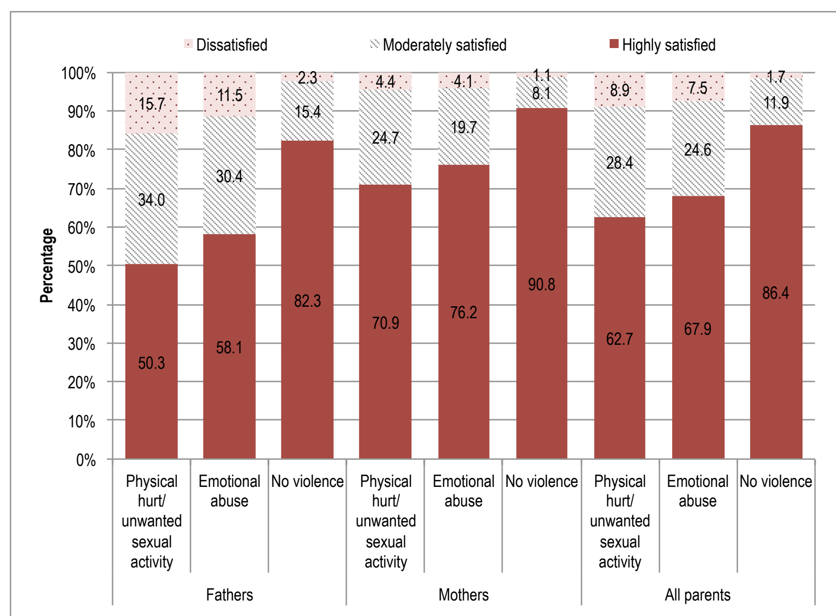
Parents' satisfaction with the wellbeing of their child showed the same pattern of results as found for physical health (Figures 3 and 4). Thus, according to mothers and fathers alike, the presence of either type of violence before/during or since separation was associated with lower rates of current satisfaction with the child's wellbeing compared to when no violence was reported (17–20% fewer of

all parents were highly satisfied if violence had occurred before/during separation, and 19–24% fewer were highly satisfied if it had occurred since). Also, rates of dissatisfaction, while rare generally, tended to be three or more times higher if violence had occurred at either time period. Particularly striking are the reduced rates of high satisfaction among fathers where either type of violence had occurred. Additionally, fathers less often reported high satisfaction when there had been physical violence than when there had been emotional abuse alone at both time periods.



Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Figure 3: Overall satisfaction with focus child's wellbeing, by parents' experiences of family violence *before/during* separation, father and mother reports



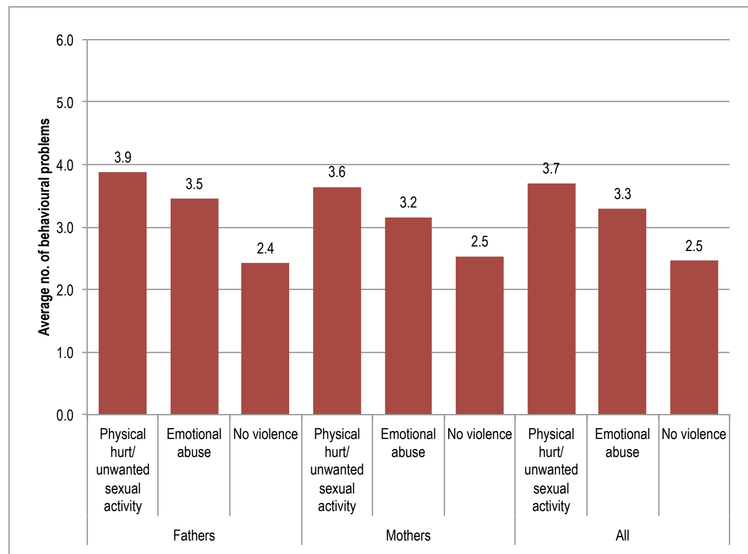
Notes: Data have been weighted.

Figure 4: Overall satisfaction with focus child's wellbeing, by parents' experiences of family violence *since* separation, father and mother reports

Behaviour problems

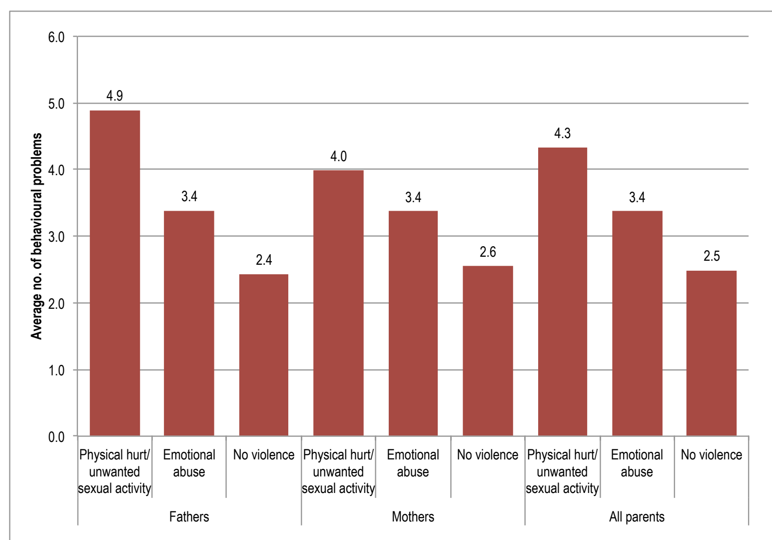
There were sizable differences among 1–3 year old children in levels of behaviour problems according to whether violence was present before/during or since separation (Figures 5 and 6). Children showed

the highest levels of problems when physical violence was reported, lower (but still somewhat elevated) levels when emotional abuse was reported, and the lowest levels when no family violence had occurred. Rates were also considerably higher than the benchmark mean of 3.1 for the whole sample. Comparing patterns over the two time periods (before/during and since separation), levels of behaviour problems were higher if family violence had occurred in the period since separation than before/during it (means of 4.3 since cf. 3.7 before/during on physical violence, and 3.4 cf. 3.3 on emotional abuse).



Notes: Data have been weighted.

Figure 5: Average number of behavioural problems (BITSEA score) for 1–3 year old children, by parents' experiences of family violence *before/during* separation father and mother reports



Notes: Data have been weighted.

Figure 6: Average number of behavioural problems (BITSEA score) for 1–3 year old children, by parents' experiences of family violence *since* separation, father and mother reports

Looking at the specific types of problem behaviours in children that were measured, differences were most evident for violence towards a parent, destructiveness, crying or hanging on when the parent tries to leave, and worrying/being nervous, with the highest rates of problems found when physical violence was present and the lowest when no family violence had occurred. Of concern was the

pattern indicating that child violence towards a parent (while relatively uncommon overall) was much more prevalent when a parent had experienced physical violence from the focus parent.

Social and learning wellbeing

While the great majority of 5–17 year olds were rated as doing better or the same as their peers on social and learning wellbeing before/during and since separation (Tables 1 and 2), a higher proportion of children were reported as doing worse if family violence of either type had occurred. Where physical violence had been reported, rates of poorer wellbeing were generally double that of children where there had not been violence; where emotional abuse had occurred, rates tended to be midway between those for physical violence and no violence. Mother and father reports were similar, and these patterns were consistent across children of differing ages (5–11, 12–14 and 15–17 years; details not shown).

Table 1: Social and learning wellbeing of school-aged focus children, by parents' experiences of family violence *before/during* separation, father and mother reports

	Fathers			Mothers		
	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)
Learning or school work	(*n* = 366)	(*n* = 837)	(*n* = 779)	(*n* = 690)	(*n* = 880)	(*n* = 614)
Much better/somewhat better	45.6	48.9	51.4	44.6	46.0	46.6
About the same	39.5	42.8	40.8	38.8	42.7	45.8
Much worse/somewhat worse	14.9	8.4	7.8	16.6	11.4	7.6
Getting on with other children	(*n* = 367)	(*n* = 833)	(*n* = 779)	(*n* = 690)	(*n* = 877)	(*n* = 623)
Much better/somewhat better	33.6	44.2	44.8	44.3	43.0	43.3
About the same	54.9	47.0	50.4	43.9	48.0	52.0
Much worse/somewhat worse	11.5	8.8	4.9	11.8	9.0	4.7
In most areas of life	(*n* = 359)	(*n* = 826)	(*n* = 769)	(*n* = 689)	(*n* = 870)	(*n* = 614)
Much better/somewhat better	32.7	36.5	45.0	36.9	38.0	40.8
About the same	56.7	54.9	50.1	49.9	51.2	54.0
Much worse/somewhat worse	10.5	8.7	5.0	13.1	10.8	5.2

Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Table 2: Social and learning wellbeing of school-aged focus children, by parents' experiences of family violence *since* separation, father and mother reports

	Fathers			Mothers		
	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)
Learning or school work	(*n* = 119)	(*n* = 1,024)	(*n* = 839)	(*n* = 193)	(*n* = 1,220)	(*n* = 771)
Much better/somewhat better	39.0	47.4	52.8	52.7	43.8	47.1
About the same	46.5	41.9	40.1	33.7	42.5	44.3
Much worse/somewhat worse	14.5	10.7	7.1	13.6	13.7	8.6
Getting on with other children	(*n* = 119)	(*n* = 1,024)	(*n* = 838)	(*n* = 193)	(*n* = 1,221)	(*n* = 776)
Much better/somewhat better	31.8	41.1	45.6	45.6	42.2	44.9
About the same	55.1	49.3	49.7	42.4	47.9	49.4
Much worse/somewhat worse	13.2	9.6	4.7	12.0	9.9	5.8
In most areas of life	(*n* = 117)	(*n* = 1,024)	(*n* = 833)	(*n* = 192)	(*n* = 1,211)	(*n* = 770)
Much better/somewhat better	34.5	34.6	45.3	37.0	35.9	42.7
About the same	55.4	56.3	49.5	50.9	52.0	51.2
Much worse/somewhat worse	10.1	9.1	5.3	12.0	12.1	6.1

Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Negative changes in patterns of behaviour

Turning now to whether there had been negative changes in children's pattern of behaviour in the past three months (Tables 3 and 4), children whose parents had experienced either type of family violence before/during or since separation tended to display double the reported rate of negative changes compared to those whose parents had not experienced violence. Most notably, approximately half the children in families where there had been physical violence had been very agitated/upset when parting from a parent, and more than 40% of those from families experiencing emotional abuse alone had shown such behaviour, compared with one-quarter of children in families where there had not been violence. Increased distress among children was also quite frequent during routine separations (e.g., when going to child care or school), with 21–31% of children whose parents reported either type of violence showing this behaviour compared with 12% of children where there had been no family violence. Slightly higher rates of irritability and distress at parting from parents (either for routine activities or at parenting changeovers) were found when there had been violence since separation compared to before/during separation. Mother and father reports were very consistent on these issues, and patterns across the five child age ranges were similar (0–2, 3–4, 5–11, 12–14 and 15–17 years; details not shown).

Table 3: Negative changes in child behaviour, by parents' experiences of family violence *before/during* separation, father and mother reports

	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)
Fathers	(*n* = 482)	(*n* = 1,084)	(*n* = 1,046)
More distressed by routine separation	26.4	24.6	11.9
More irritable or upset	30.1	24.5	12.4
Agitated or upset when parting from parent	50.3	41.4	25.3
Social interactions worse	16.9	13.4	5.9
Professional expressed concerns	13.7	13.5	7.0
Mothers	(*n* = 1,006)	(*n* = 1,188)	(*n* = 935)
More distressed by routine separation	24.4	20.5	11.6
More irritable or upset	29.6	27.6	17.0
Agitated or upset when parting from parent	49.2	42.5	22.0
Social interactions worse	17.2	11.7	7.0
Professional expressed concerns	18.0	17.3	9.4

Notes: Data have been weighted. Sample size for each statement/violence category varies due to exclusion of "don't know" and "refused" responses from the analysis. Table shows smallest responding sample size for each statement for fathers and mothers.

Table 4: Negative changes in child behaviour, by parents' experiences of family violence *since* separation, father and mother reports

	Physical hurt and/or unwanted sexual activity (%)	Emotional abuse (%)	No family violence (%)
Fathers	(*n* = 169)	(*n* = 1,318)	(*n* = 1,126)
More distressed by routine separation	30.4	24.8	12.4
More irritable or upset	32.8	26.7	11.7
Agitated or upset when parting from parent	56.9	44.4	24.3
Social interactions worse	15.9	14.8	5.8
Professional expressed concerns	15.0	13.6	7.1
Mothers	(*n* = 277)	(*n* = 1,712)	(*n* = 1,140)
More distressed by routine separation	30.7	22.1	11.8
More irritable or upset	34.8	29.1	16.5
Agitated or upset when parting from parent	56.4	46.6	21.8
Social interactions worse	16.5	13.9	8.2
Professional expressed concerns	20.5	17.4	10.4

Notes: Data have been weighted. Sample size for each statement/violence category varies due to exclusion of "don't know" and "refused" responses from the analysis. Table shows smallest responding sample size for each statement for fathers and mothers.

Children's wellbeing and witnessing family and domestic violence

The following discussion of the wellbeing of children who witnessed family violence of either kind (physical violence or emotional abuse) is based on data from SRSP 2012. Children were divided into five groups:[8]

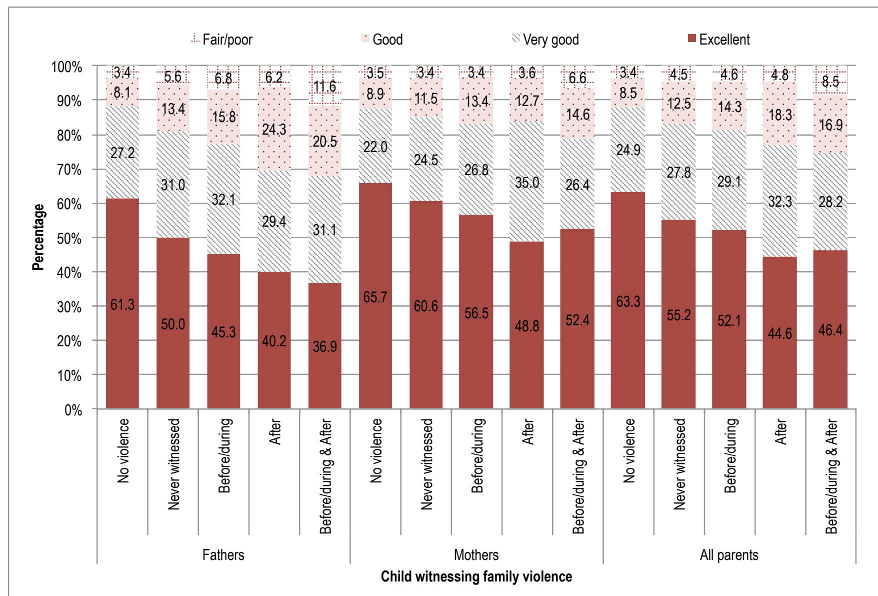
- no violence within the family (*n* = 1,651);
- violence within the family, never witnessed (*n* = 1,502);
- witnessed violence before/during but not since separation (*n* = 1,011);
- witnessed violence since but not before/during separation (*n* = 402); and
- witnessed violence both before/during and since, separation (*n* = 1,389).

As can be seen from the numbers in the five groups, above, 28% of children were in separated families in which violence had never taken place, and an additional 25% had not witnessed the violence that had occurred within the family. If children witnessed violence, most commonly they witnessed it at both time periods (before/during and since separation; 23%). Next most common was for children to have witnessed violence between parents before/during but not since separation (17%), while 7% of children witnessed violence only since separation. Looking only at families in which violence had occurred, the data reveal that 65% of children in those families had witnessed violence at some stage. It was not possible to explore the effects of witnessing different types of family violence in these analyses (physical violence or emotional abuse) as group numbers were too small for reliable patterns to be obtained.

Level of physical health

Across father and mother reports, there was a consistent pattern showing that children who had witnessed family violence at both time periods or since separation only were doing less well on physical health than children who had never witnessed the violence that had occurred within their families or had witnessed it only before/during separation (Figure 7). For example, 8–19% fewer of these children were in excellent heath and 4–7% more were in fair/poor or only good health. These patterns suggest that the recency of witnessing violence may have been most salient for children's health. There was also an indication that children from families in which there had never been violence to be doing better than children in families where violence had occurred, regardless of whether children had witnessed it. Nevertheless, it should be noted that a large majority of children were reported to be in excellent or very good health overall.

[8] In a small number of cases (*n* = 54), parents did not know whether the child had witnessed the violence that had occurred. These children were excluded from the analyses.

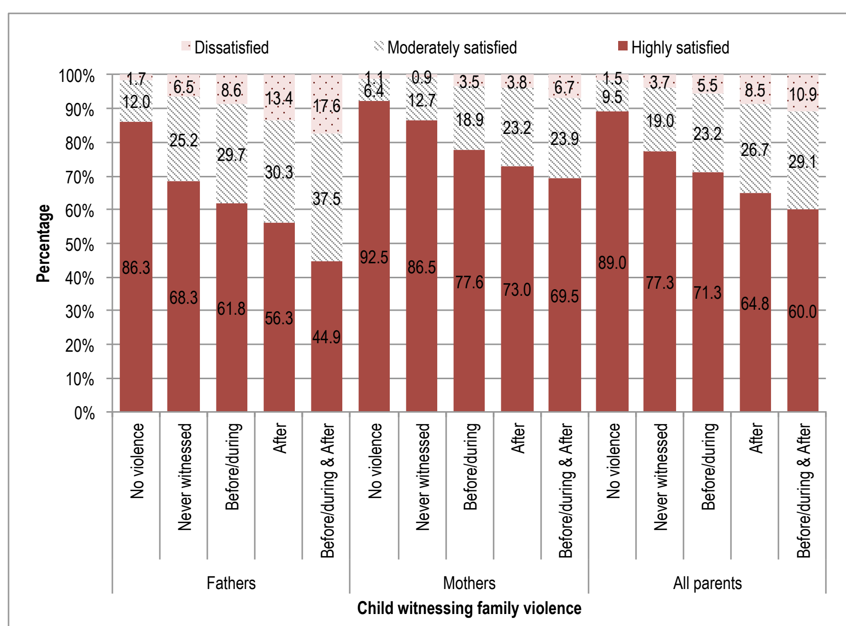


Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Figure 7: Level of focus child's physical health, by whether witnessed family violence, father and mother reports

Satisfaction with overall child wellbeing

While fathers and mothers generally differed on how satisfied they were with the wellbeing of their children (Figure 8), both sets of parents consistently expressed less satisfaction when their children had witnessed violence. Rates of high satisfaction declined steadily from 89% of parents where there had not been violence, to 77% when there had been violence but children had not witnessed it, to 71% when violence was witnessed before/during separation, to 65% when violence was witnessed since, and to 60% when violence was witnessed at both time periods. Rates of dissatisfaction showed corresponding increases, depending on whether there had been violence, whether it was witnessed and when. There were differences, too, according to when the violence had been witnessed, with parents expressing most dissatisfaction when this had been over an extended period (both before/during and since separation) and the least when this had been before/during the separation but not since, with rates midway between when children had witnessed violence since but not before/during separation. Notably, when children had witnessed violence over an extended period, 55% of fathers, 30% of mothers and 40% of parents overall were dissatisfied or only moderately satisfied with the child's wellbeing.

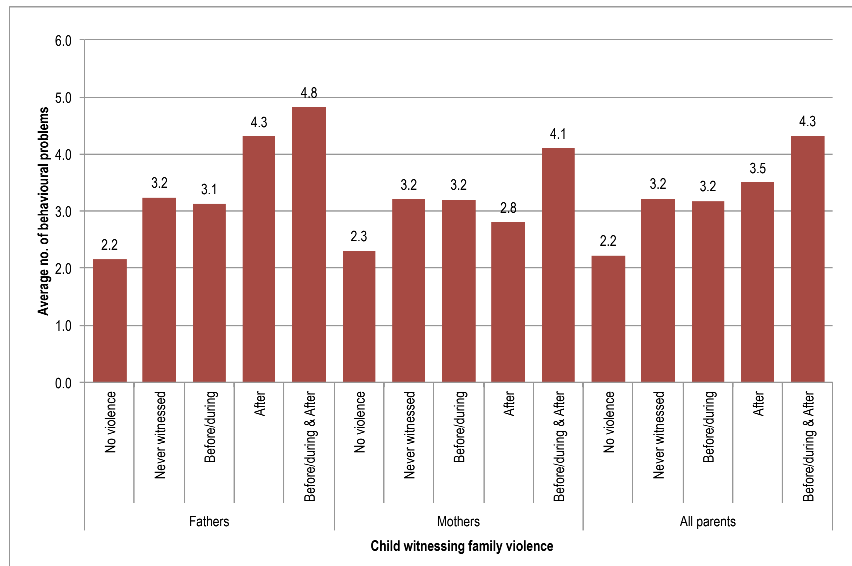


Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

Figure 8: Overall satisfaction with focus child's wellbeing, by whether witnessed family violence, father and mother reports

Behaviour problems

One- to three-year-old children tended to have considerably higher levels of behaviour problems as measured by the BITSEA total score if they had witnessed family violence over an extended period (i.e., before/during and since separation), as indicated by Figure 9. Surprisingly, according to the reports of both sets of parents, children who had witnessed family violence before/during separation had lower levels of behaviour problems than children who had never witnessed the violence that had occurred within their families. Also, according to mothers, if children had witnessed violence since separation, they showed fewer behaviour problems relative to children who had never witnessed it (fathers' reports were very different on this comparison, however). This unexpected pattern may be due to low numbers in some groups (e.g., in the group where the child had witnessed violence before/during but not *since* separation, there were 39 fathers and 100 mothers, while in the group that had witnessed violence since separation, there were only 22 fathers and 37 mothers). These relatively low group numbers may have made the responses for some groups more vulnerable to individual variation. It should also be noted that levels of behaviour problems were much higher among all groups in which family violence had occurred (whether or not it was witnessed) when compared to the group in which violence had never occurred.



Notes: Data have been weighted.

Figure 9: Average number of behavioural problems (BITSEA score) for 1–3 year old children, by whether witnessed family violence, father and mother reports

Social and learning wellbeing

Turning now to the social and learning wellbeing of 5–17 year olds (Table 5), there was a small but consistent pattern indicating that a higher proportion of children who had witnessed family violence over an extended period (before/during and since separation) were faring worse than children who had witnessed violence at only one time period or had never witnessed it. Thus, among all parents, around 4% fewer of children who witnessed violence at both time periods were seen to be doing better than other children, while around 4% more were perceived to be doing worse, with fathers' outcomes reports showing more marked differences than mothers'. No consistent differences between the other groups of children were discernible (data not shown).

Table 5: Social and learning wellbeing of school-aged focus children, by whether witnessed family violence, father and mother reports

	No violence (%)	Never witnessed (%)	Before/ during (%)	Since (%)	Before/ during & since (%)
Fathers					
Learning or school work	(*n* = 628)	(*n* = 452)	(*n* = 286)	(*n* = 139)	(*n* = 407)
Much better/somewhat better	51.2	51.4	50.9	52.2	43.4
About the same	41.9	39.4	41.5	35.9	43.8
Much worse/somewhat worse	6.9	9.1	7.7	11.9	12.7
Getting on with other children	(*n* = 624)	(*n* = 457)	(*n* = 284)	(*n* = 141)	(*n* = 403)
Much better/somewhat better	45.7	44.1	41.6	45.6	35.8
About the same	50.1	48.6	51.2	44.2	51.8
Much worse/somewhat worse	4.2	7.3	7.2	10.2	12.5
In most areas of life	(*n* = 619)	(*n* = 446)	(*n* = 285)	(*n* = 140)	(*n* = 392)
Much better/somewhat better	46.6	38.9	37.6	34.6	35.8
About the same	49.6	53.9	54.7	55.5	51.8
Much worse/somewhat worse	3.8	7.2	7.7	10.0	12.5
Mothers					
Learning or school work	(*n* = 484)	(*n* = 425)	(*n* = 426)	(*n* = 155)	(*n* = 647)
Much better/somewhat better	47.0	46.9	41.7	47.1	46.7
About the same	45.0	42.2	43.8	45.1	22.5
Much worse/somewhat worse	8.0	10.9	14.6	7.8	15.3
Getting on with other children	(*n* = 492)	(*n* = 424)	(*n* = 423)	(*n* = 155)	(*n* = 650)
Much better/somewhat better	45.5	42.9	43.0	39.4	43.7
About the same	49.7	50.0	48.4	50.1	43.8
Much worse/somewhat worse	4.8	7.1	8.6	10.5	12.5
In most areas of life	(*n* = 483)	(*n* = 428)	(*n* = 416)	(*n* = 154)	(*n* = 644)
Much better/somewhat better	43.5	37.3	39.7	34.5	43.7
About the same	50.9	54.0	51.6	57.3	43.8
Much worse/somewhat worse	5.6	8.7	8.7	8.3	12.5

Notes: Data have been weighted. Percentages may not total exactly 100.0% due to rounding.

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

The AIFS DFV Children Report found that, overall, there is a lack of evidence about the outcomes for children affected by DFV who engage with services, programs and support. This is largely due to a lack of rigorous evaluation of DFV services. DFV services often lack the resources to undertake or participate in evaluation. There is, however, a significant amount of high quality practice knowledge within the sector about the best approaches to take with children affected by DFV.

Response services

There is relatively little literature that considers the most effective responses to children who have been exposed to violence. 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 outline key areas of direction 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 and children's services;
- developing therapeutic programs that address the mother and child bond;
- offering therapeutic responses involving 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.

Responses to children should also be culturally and religiously appropriate.

Early intervention and primary prevention programs

School-based programs

There is general consensus in the literature that there is a lack of evidence for what works with children in the arena of DFV early intervention and prevention programs. However, methodological reviews, meta-analyses and reviews of literature indicate that there is a greater evidence base for the efficacy of prevention strategies with children and young people that are delivered through schools (Chalk, 2000; Flood & Fergus, 2008; Hester & Westmarland, 2005; Murray & Graybeal, 2007; Whitaker et al., 2006; Whitaker, Murphy, Eckhardt, Hodges & Cowart, 2013). As such, the World Health Organization (2010) and VicHealth (2007) recommended school-based primary prevention with children and young people, and school-based primary prevention is also supported in the National Plan (COAG, 2009) and many state policies. The nationwide Respectful Relationships in Australian Schools program is funded through the National Plan (COAG, 2009). Most school-based prevention programs are delivered in secondary schools. There is little evidence about effective practice with younger children; however, there is a strong argument for primary prevention to begin in pre- and primary school levels given that attitudes towards gender and violence may already be ingrained by the time children reach secondary school age (Ellis, 2008; Flood & Fergus, 2008).

Programs for pregnant women and new parents

Pregnancy and early parenthood are recognised as high-risk periods for DFV and it is thought that this may be a critical period to prevent DFV that children may otherwise be exposed to (Campbell, Garcia-Moreno, & Sharps, 2004; Taft et al., 2013). However, there is a lack of evidence for effective interventions for this target group (Taft et al., 2013). There is some evidence to suggest that home visitation programs in early infancy may be effective. A meta-analysis examining the efficacy of primary prevention programs indicated that home visitation programs by nurses or social workers might be effective in reducing DFV among vulnerable families (Chalk, 2000). However, there are very few studies or evaluations of home visitation programs that were specifically focused on the prevention of DFV. Most are more overtly aimed at the prevention of social isolation, family dysfunction, child abuse and maltreatment rather than DFV, though DFV is often present in the families targeted by such programs (Evanson, 2006). Community education programs aimed at new parents—for instance those delivered though maternal child health centres—are an emerging area for primary prevention strategies (Walden, 2014).

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

One of the most important implications for practice that emerged from the AIFS DFV Children Report is the need for a comprehensive and coherent policy framework to support understanding and practice of DFV responses, prevention and early intervention for children affected by DFV. Over the last 20 years or so, there has been a move in many jurisdictions to adopting 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. The 2009 National Plan (COAG, 2009) provides a good framework for this to occur, particularly if states have complementary policies and frameworks in place. The DFV Children Report suggests a significant need for better integration of services for children, including better communication and integration between family violence services and other systems, including the child protection system, the state-based justice system, family support systems such as those that deliver maternal and child health services, and the education system. A clear and coherent policy framework is needed at state and federal levels to support understanding and practice of DFV responses, prevention and early intervention to better enable discrete service sectors to work towards common goals and ensure children's needs are met across the various sectors.

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

The empirical evidence base on the needs and experiences of children affected by family violence is underdeveloped in many areas. As demonstrated in the earlier discussion on prevalence, family violence occurs across a spectrum of severity but there is a dearth of evidence on the implications of this for children. Some legislative definitions (e.g., s 4AB of the *Family Law Act 1975* (Cth)) refer to family violence as behaviour that causes fear, coercion and control; but from child's perspective, violent behaviour may well have adverse impacts in the absence of these features.

The DFV Children Report found that there is a need for further research and evaluation of existing response, early intervention and prevention practice models for children aged 0–8 years. Particularly in the early intervention and prevention domains, there has been a focus on older children. For older children, there is a growing evidence base indicating the effectiveness of school-based programs. A similar evidence base is needed in relation to younger children in order to establish which practices are most effective.

From a resilience perspective, there is a need for more research that examines the variability in impact and sheds light on the factors and interventions that mitigate negative effects and support recovery. Conversely, there is also a need for more empirical evidence on the factors that contribute to greater negative effects and militate against recovery. In this context, the ANROWS-funded PACTs project will shed light on the impact of family violence on parenting and the kinds of services and supports that assist in recovery of parenting capacity after family violence.

Concluding remarks from ANROWS

Through our research program, ANROWS is committed to building the evidence base by mapping and analysing good policy and practice models to prevent violence and improve access to, and responses of, services for women and their children experiencing or at risk of violence. The National Children's Commissioner should be aware that ANROWS funding ($3 million per annum, shared across the Commonwealth and all state and territory governments of Australia on a per capita basis) commenced on 1 July 2013 for a three-year period until 30 June 2016. That is, the current commitment of funding for ANROWS expires six years before the end of the National Plan. A longer term funding commitment (at least to the end of the National Plan in 2022) is necessary to enable ANROWS to fulfil its potential, including providing support for longer term research projects, which are crucial in understanding, for example, the effects of perpetrator intervention programs. To illustrate this point, the open grants applications process conducted by ANROWS for its Research Program 2014–2016 resulted in 50 applications for research projects to address current gaps in the evidence base, with a total value of approximately $15 million; however, ANROWS has been able to fund a Research Program valued at $3.5 million.

The need for and capability to deliver an evidence base for effective activities to reduce and prevent violence is far greater than the current commitment of resources for this purpose. The need for evidence to support policy and practice in work towards eliminating domestic violence will continue well beyond the term of the current National Plan. A solid foundation and evidence base on family, domestic and sexual violence requires collecting consistent and comparable data, and producing and translating research- and practice-based evidence. ANROWS remains deeply committed to producing nationally relevant and translatable research evidence to support the National Plan. We appreciate this opportunity to contribute to the Commissioner's deliberations and would be very pleased to assist further if required.

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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.

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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*.
Our understanding is that jurisdictions have been provided with a copy of this Report. Relevant contact would be the area in DHHS responsible for the National Framework coordination.

Quadara, A., Nagy, V., Higgins, D., & Siegel, N. (2014). *Conceptualising the prevention of child sexual abuse. Final Report*. Melbourne: AIFS.

Or if you have trouble, we can pass on the details of a contact in DSS you can contact to obtain a copy. (We are currently in the process of negotiating agreement to publish the report as an AIFS Research Report)

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

Australian Institute of Family Studies

The Australian Institute of Family Studies (AIFS) is a Melbourne-based statutory agency of the Australian Government, established in February 1980 under the Australian *Family Law Act 1975*. The Institute operates within the Department of Social Services (DSS), formerly the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). The Institute also has close links with the Attorney-General's Department, the Department of Education, the Department of Human Services, the Department of the Prime Minister and Cabinet, the Department of Veterans' Affairs and other Australian Government portfolios, their departments and agencies.

The Institute aims to increase understanding of factors affecting how Australian families function by conducting research and communicating findings to policy-makers, service providers, researchers and the broader community. The AIFS Strategic Directions and Research Directions documents set the framework for its research activities and guide the research undertaken, including commissioned projects. The Institute facilitates and communicates research findings through its research publications, conferences, websites, information exchanges, information services, presentations, seminars and webinars, representation and through mass media. The *Strategic Directions 2012-15* came into effect on 1 July 2012. The plan outlines the roles and functions of the Institute for this annual reporting period. The key strategic objectives are:

- undertaking high-quality impartial research relating to the wellbeing of families in Australia;
- sharing the information and transferring our knowledge;
- valuing and developing our relationships; and
- managing our organisation.

Australia's National Research Organisation for Women's Safety

Australia's National Research Organisation for Women's Safety Limited is an independent, not-for-profit organisation established as an initiative under Australia's National Plan to Reduce Violence against Women and their Children 2010–2022 (the National Plan). ANROWS is jointly funded by the Commonwealth and all state and territory governments of Australia. Our mission is to deliver relevant and translatable research evidence which drives policy and practice leading to a reduction in the incidence and impacts of violence against women and their children. ANROWS was registered as the National Centre of Excellence to Reduce Violence against Women and their Children, a company limited by guarantee, in February 2013. It was officially launched with the name Australia's National Research Organisation for Women's Safety (ANROWS) on 16 May 2014, along with the National Research Agenda to Reduce Violence against Women and their Children (National Research Agenda) it produced on behalf of the Commonwealth and state and territory governments and its research priorities under the National Research Agenda. The ANROWS Research Program 2014–16 (Part 1) was launched on 31 October 2014. The Research Program consists of 20 projects across five strategic research themes and these projects have a combined total value of approximately $3.5 million. The projects incorporate: 1) projects funded as part of ANROWS's Research Priorities Grants round, which was an open, competitive process for researchers to apply for grants in priority topic areas. 2) multi-jurisdictional national projects, supported by advisory groups with appropriate expertise in the relevant topic, with researchers identified through a competitive, expression of interest process. 3) small-scale, commissioned projects that provide a conceptual or theoretical underpinning for subsequent empirical research. These projects have an ambitious reach with research sites in every state and territory and a spread of projects focusing on different types of violence against women as well as priority population groups identified in the National Research Agenda. Our program of research comprises projects within priority topic areas directly related to jurisdictions' needs for evidence to support their implementation of the National Plan.

Australian Government

Australian Institute of Family Studies

National Children's Commissioner

Examination of children affected by family and domestic violence

Submission from the
Australian Institute of Family Studies (AIFS)
and
Australia's National Research Organisation for Women's Safety Ltd.
(ANROWS)

Attachment A

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

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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

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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.

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.

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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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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