

Connecting services:

Learning from child death inquiries when the co-existing parental characteristics of family violence, substance misuse and mental illness place children at risk

Published by Office of the Child Safety Commissioner,
Melbourne, Victoria, Australia.

August 2012

© Copyright State of Victoria, Office of the Child Safety
Commissioner, 2012.

ISBN 978-0-7311-6539-1

This publication is copyright. No part may be reproduced
by any process except in accordance with the provisions
of the *Copyright Act 1968*.

Authorised by the Victorian Government,
570 Bourke Street, Melbourne.

Foreword

Increasingly, children from families where family violence, parental substance misuse and parental mental illness co-exist are being reported to Child Protection services. This trend has been mirrored in the cases referred to my office for child death inquiries.

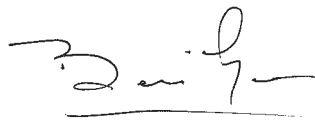
My office has completed a report based on these cases which reinforces the need for an integrated whole of government response to families with multiple and complex issues. It is vital that we work together and all assume responsibility for improving the safety and wellbeing of vulnerable children in our Victorian community.

This report reviews relevant research and policies and analyses the cases to identify opportunities for service improvement. It contains key messages, findings and implications for practice to guide future responses to families experiencing multiple issues whose children are reported to Child Protection services.

The intention of my office is to contribute to the discussion on integrating service delivery and to ensure the learning contained in this report is acted upon, so that better outcomes are achieved for children in highly vulnerable families.

The timing of the report coincides with initiatives across the sectors promoting a strong focus on children, improving service collaboration and adopting a whole of government approach to service delivery.

I extend my sympathy to the families, friends and professionals who were involved with the children whose cases were examined. I hope that the report will, in some way, acknowledge and place value on their short lives.

A handwritten signature in black ink, appearing to read 'Bernie Geary', with a horizontal line underneath.

Bernie Geary OAM
Child Safety Commissioner

Acknowledgements

This group analysis was commissioned by the Office of the Child Safety Commissioner and the Victorian Child Death Review Committee.

The foundation research and analysis of 16 child death inquiries from 2004–2008 was conducted by a consortium led by La Trobe University and comprising; Associate Professor Margarita Frederico Head Department of Social Work and Social Policy, Associate Professor Annette Jackson Director, Take Two Berry Street, Dr Jenny Dwyer Consultant, with Dr Stefan Gruenert Chief Executive Officer, Odyssey House Victoria and Joanna Bock, Berry Street. In addition to the analysis of child death reviews a literature review, a survey of stakeholders, and focus groups were undertaken guided by a reference group.

The analysis was later expanded by the Inquiries and Review Unit of my office to include a further 25 child death inquiries.

The contribution is gratefully acknowledged of the consortium led by La Trobe University and those individuals who participated in focus groups or provided feedback on the analysis for their invaluable contribution to our understanding of the impact of parental risk factors on the lives of vulnerable children and the implications for effective service delivery.

The input of the Victorian Child Death Review Committee is also much appreciated.

The significant work undertaken by the Inquiries and Review Unit on this project is also gratefully acknowledged.

Executive summary

This report presents an analysis of 41 child death inquiries from 2004–11, conducted by the Office of the Child Safety Commissioner (OCSC), in which the three parental risk factors of family violence, substance misuse and mental illness were present.

The purpose of this group analysis is to assist in understanding the impact of the co-existence of these factors on the child when all three risk factors are present and to propose a model for service development to achieve a more integrated practice approach.

Methodology

The research methodology was built around available documentation for the 41 cases. It included: a literature review; a survey of service providers for feedback in relation to their experience of working with the three risk factors when collaboration between sectors and Child Protection is involved; and two focus groups of representatives from the service sectors.

Key outcomes

Messages from research

The analysis identified extensive literature available on the separate risk factors associated with family violence, parental substance misuse and parental mental illness. However, significantly less research is available when these risk factors co-occur and even less about children who are subject to Child Protection intervention and in the care of adults experiencing those multiple issues.

Research is clearly needed to more accurately explore and measure:

- the impact of these multiple and interconnecting risk factors on vulnerable children and their families within a Child Protection context
- the impact of service integration on vulnerable children and their families within a Child Protection context
- the effectiveness of service integration between Child Protection, family violence, alcohol and other drugs and adult mental health sectors.

Government reviews and initiatives in Australia and the United Kingdom recognise that in order to achieve positive outcomes for vulnerable children and families with multiple risk factors services need to work together.

The children and their families

Family violence, parental substance misuse, and parental mental illness impact upon the individual and on their capacity to parent, especially when these factors co-exist. For children where all three parental risk factors are present, the risk to the child's safety and to their ongoing development can be severe. The cases demonstrated this across the three risk factors.

■ *Family violence*

The impact of the children's exposure to family violence was frequently minimised by both parents. Children experienced feelings of fear and a sense of powerlessness which were further compounded by their exposure to police intervention, separation from their mother during hospitalisation and uncertainty about their family's future.

■ *Substance misuse*

The impact of the parental substance misuse varied due to its type, extent and the ages of the children affected. The children were at increased risk of poor developmental outcomes, neglectful parenting and abuse. Their family life was often characterised by chaos and unpredictability, with changing structures and inconsistent rules.

■ *Mental illness*

There appeared to be little understanding by Child Protection practitioners about the diagnosed mental illnesses and how they impacted on parental functioning and the children's experience of living with a parent with a mental illness on a daily basis. When the parents were preoccupied with their own chaos they were less able to protect the child from their own symptoms and from other sources of harm.

Evidence of a multi-service response

Intervention to support and protect children requires a multi-service system response to match the multi-layered problems they experience.

The analysis found little evidence of an integrated multi-service response across the cases which were known to have involvement with adult services. The presence of parental risk factors did not necessarily result in referrals and engagement with specialist adult services.

Parental risk factors were not always aligned with relevant adult services and in the few cases where this did occur, there was an absence of a collaborative and synchronous interaction between Child Protection, family violence, alcohol and other drug and mental health services.

The three parental risk factors commonly coincided with economic and social disadvantage and intergenerational issues of risk were also evident in the cases considered.

The analysis illustrates that it is the implementation of the cross-sectoral work between adult and child services which requires more active attention.

The analysis demonstrates that effectively intervening with families with the three parental risk factors requires a whole of government response, integrated service delivery across multiple sectors and an approach of sharing responsibility for vulnerable children.

Framework for a multi-service system response

Families presenting with the identified risk issues present significant challenges for Child Protection and specialist adult services. A comprehensive and balanced understanding of multiple parental risk factors is required by both child and specialist adult services.

The analysis found that effective collaboration needs to underpin work with highly vulnerable families and children and proposes a framework to guide thinking about developing an integrated service response.

This framework for a multi-service system response comprises the following components:

■ **Leadership**

The combination of multiple parental risk factors creates a dynamic that requires a concerted and concentrated effort by child and specialist adult services ‘... to look beyond their individual specialisms and to think more broadly to acknowledge the impact of parental behaviour on children...’ (Brandon et al., 2005; Cleaver et al., 1999; Brandon et al., 2008). For this to occur, a robust leadership approach is required to support and facilitate the necessary changes across all levels of each service system.

■ **Policy and legislative strategies**

Barriers to effective collaboration need to be addressed at the policy level, as well as at the program and practice level. Constraints to collaboration identified in this project include:

- different legislative requirements
- different government departments
- different systems and structures
- insufficient knowledge across the systems
- information sharing barriers
- different professional terminology/‘language’
- complex systems needed to manage demand for services and finite resources.

Policy can be a proactive force in leading the implementation of change, overcoming barriers that may exist in organisational culture and practice and identifying program development options.

■ **Service systems and collaboration strategies**

Some of the strategies to improve and support effective collaboration may include: establishing

new structures and processes; adapting existing structures and processes; and developing time-limited processes at central and local levels that require and enable collaboration and may lead to new initiatives. Knowledge building and workforce development are two such initiatives that provide opportunities for purposeful collaboration between professionals across Child Protection services and specialist adult services.

■ **Program strategies**

When working with families with complex and multiple needs, services need to work together to deliver an integrated multi-service system response. Greater capacity building across all four sectors is needed to recognise, engage and effectively respond to the needs of both children and adults. O'Connor's (2002) report on mental health services and Child Protection, suggested the following program initiatives:

- embedding adult-service workers in child-focused services
- embedding child-focused workers in adult services
- creating portfolios in each service pertaining to the other
- coordinating assessments between adult-focused and child-focused services.

■ **Practice and intervention strategies**

Meaningful connection between services can be promoted through relevant case discussions that address all relevant risk factors and the impact of these risk factors on the adult's capacity to function adequately as a parent, in order to ameliorate the risk of harm to the child.

Irrespective of purpose (whether for information and advice or assessment purposes), the exchange of information between services needs to be appropriately focused and relevant to the risk factors identified for the child. Developing practice strategies to assist professionals in managing the volume and complexity of information in cases that present with multiple risk factors is therefore required.

Conclusion

The group analysis has shown that when families experience multiple issues, Child Protection and specialist adult services are likely to intersect. Specialist adult services all have an important role to play in the protection, safety and wellbeing of children. Family violence services, alcohol and other drug services and mental health services can help reduce the risk of child abuse and neglect through improved and effective collaboration across all levels of service delivery.

The practice of working collaboratively needs to be valued, supported and adequately resourced by all services. Collaboration needs to be modelled and structurally supported by senior staff and managers in the Child Protection, family violence, alcohol and other drug and mental health service sectors. Linkages between services are more likely to occur when appropriate resources are made available to support the workforce in working collaboratively.

This analysis has demonstrated that a concerted effort needs to be made by all child and specialist adult services to systematically address the constraints that impede the successful development of a multi-service system response to vulnerable children and their families. The move from single independent services to a more joined up approach requires a major change in thinking across all levels of service provision to ensure the goal of achieving better outcomes for vulnerable children and families is realised.

Effective collaboration needs to underpin work with highly vulnerable families and children. While this message is not new, the challenge remains about implementing what has been learned and embedding it into day to day practice to benefit vulnerable children and their families.

Contents

Foreword	1
Acknowledgements	2
Executive summary	3
Section 1: Introduction	8
Section 2: Methodology	10
Section 3: Messages from research	11
Section 4: Service system responses to multiple risk factors	15
Section 5: The children and their families	20
Section 6: Evidence of a multi-service system response	33
Section 7: A framework for a multi-service system response	38
Section 8: Conclusion	42
Glossary	44
Abbreviations	46
References	47
Appendix 1: The potential impacts on the child of the three parental risk factors	48
Appendix 2: Key messages from research	49
Appendix 3: Findings and implications for practice	50

1. Introduction

Over the years research has drawn attention to a range of complex risk factors associated with child abuse and neglect and in particular factors relating to issues of family violence, parental substance misuse and parental mental illness. These three risk factors, also referred to nationally as 'particular behaviours' or 'characteristics of parents' (Commonwealth of Australia, 2009), are the same key risk factors identified through Victoria's system of inquiry regarding children known to Child Protection who have died.

The scale and complexity of family violence, parental substance misuse and parental mental illness as single risk factors present a range of policy and practice challenges for Child Protection, family support and specialist adult services. When these three risk factors co-exist the degree of complexity and the extent of the challenges increase significantly; reducing the parent's capacity to provide adequate care and protection and increasing the likelihood of harm to the child.

All services have an important role to play in the protection, safety and wellbeing of children. Without timely and effective intervention by Child Protection, family support and specialist adult services, children remain at risk of abuse and neglect. An integrated multi-service system response is one step towards reducing this risk and enhancing the lives of Victoria's vulnerable children and their families.

Background

In June 2009 the Office of the Child Safety Commissioner (OCSC), in collaboration with the Victorian Child Death Review Committee, commissioned a group analysis of 16 child death inquiry reports to contribute to learning about responding to the co-existence of family violence, parental substance misuse and parental mental illness and to consider options for an integrated multi service system response to improve the wellbeing and protection of vulnerable children. The group analysis of 16 cases was undertaken by a consortium led by La Trobe University. The analysis focused on a sample of child death inquiry reports where the lives of the children were characterised by parents who experienced their own significant issues in terms of the three identified risk factors.

While the initial group analysis was in progress, a further 25 child death inquiries were conducted by the OCSC which also contained the three parental characteristics and provided additional opportunities for contemporary learning. It was determined by the OCSC that the original study cohort would be expanded to include these more recent additional 25 cases. The evidence from these new cases reinforced that the original identified issues remain a challenge for contemporary practice.

The work undertaken by the La Trobe University consortium provided the basis and framework for the revised analysis.

This report is therefore based on an analysis of 41 child death inquiry cases from 2004–2011.

Purpose of this group analysis

This report examines the response provided by Child Protection, family services and specialist adult services to enhance understanding of how they intersect and how they can work together to provide an effective and integrated multi-service system response to vulnerable children and their families. The analysis is based on five terms of reference:

1. to review current knowledge and research evidence in relation to the impact of the co-existence and interaction of the parental risk factors associated with family violence, substance misuse and mental illness on parenting capacity and the developmental needs of children
2. to identify practice models across child-focused services (Child Protection and family services) and specialist adult-focused services that facilitate an integrative and multi-service system response to assessing the impact of family violence, substance misuse and mental illness on parenting capacity and the developmental needs of children
3. to identify practice models across child-focused services and specialist adult services that facilitate an integrative and multi-service response aimed at mitigating risk to children by working effectively with families in which problems relating to Child Protection, family violence, mental illness and substance misuse co-exist

4. to conduct an analysis of identified child death inquiry cases and document themes and issues relating to the service system's response in assessing, planning and managing the impact of family violence, parental mental illness and parental substance misuse on parenting capacity and the developing child
5. to develop a framework and strategies for a multi-service system response which identifies necessary changes in current processes within each of the discrete service systems and options for achieving the goal of a multi-service system response.

2. Methodology

The report is based on a qualitative analysis of a cohort of 41 child death inquiry cases. The 41 cases were purposively selected to further understanding of three parental risk factors that are known to commonly co-exist in high risk vulnerable families known to Child Protection. A child death inquiry for each case was conducted by the Office of the Child Safety Commissioner in accordance with the *Child Wellbeing and Safety Act 2005*.

Information for each case was obtained from key documents and reports from the Office of the Child Safety Commissioner and the Department of Human Services' Child Protection program.

The amount of information available across the cases varied significantly depending on the level of service response; some cases were closed at intake, while those that proceeded to protective intervention contained more data about the families and the agencies working with them.

Information from the Victorian Child Death Review Committee and the Coroners Court was also considered when available.

The process of analysis involved an examination of each child death inquiry case in order to establish the prevalence of the three risk factors in each report, the impact on parenting and the developing child and the response provided by Child Protection, family support and specialist adult services.

The La Trobe University consortium undertook a comprehensive literature review, along with a survey and focus group meetings with professionals to identify issues within and across service sectors.

The analysis was considered within the context of relevant legislation and established Child Protection programs, policies and practice standards, current research and thinking in the relevant service sectors.

3. Messages from research

Key message

When there is more than one parent-based risk factor present, the likelihood of risk and the consequences of harm for the child can increase exponentially.

There is extensive literature available on the separate risk factors associated with family violence, parental substance misuse and parental mental illness. However, there is significantly less research available when the three risk factors co-exist. There is even less research about children who are subject to Child Protection intervention and in the care of adults experiencing these multiple issues in Victoria and more broadly across Australia.

Research is clearly needed to more accurately explore and measure:

- the impact of multiple and interconnecting risk factors associated with family violence, parental substance misuse and parental mental illness on vulnerable children and their families within a Child Protection context
- the impact of service integration on vulnerable children and their families within a Child Protection context
- the effectiveness of service integration between Child Protection, family violence, alcohol and other drugs and adult mental health sectors.

The interconnecting nature and complexity of the three risk factors has been highlighted in research by Dr Joanne Baker and colleagues in 2006, who noted that 'while various studies have attempted to consider parental issues of disability, mental illness, problematic substance use and/or domestic violence as distinct and independent variables, in fact they are complex, convoluted and intertwined' (Baker et al., 2006).

In 2008 an analysis of serious case reviews in England found that the families of an intensive sample of 47 cases shared many characteristics, particularly family violence, parental mental health problems and parental substance misuse and that it was more common for these factors

to exist in combination than on their own. This analysis found that 'there was little evidence of shared expertise between specialist services' and reported that 'safer practice requires professionals from different agencies to look beyond their individual specialism and to think more broadly to acknowledge the impact of parental behaviour on children in the household' (Brandon et al., 2008).

In April 2009 the Council of Australian Governments endorsed the *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children* (the National Framework). The commonwealth, state and territory governments agreed to work together to implement a comprehensive national approach to protecting children in response to the increasing number of Australian children exposed to child abuse and neglect. The National Framework outlines a long-term national approach to ensure the safety and wellbeing of Australian children and reduce the level of child abuse and neglect. Of the twelve national priorities identified, one relates to 'joining up service delivery' (Commonwealth of Australia, 2009).

In the United Kingdom, government reviews have also increasingly focused on the importance of developing effective multi-agency practices. The *Protection of Children in England* report by Lord Laming refers to the significant number of children living in households where there was a known high risk of family violence, alcohol and drug misuse and mental health problems and that these issues were a consistent feature of serious case reviews. Laming indicated that these were complicated matters that 'need to be handled with great care' and that 'the answer must lie in joint working between police, health and children's services to ensure that the risk of harm to children is well understood, assessed and acted upon appropriately in every case' (Laming, 2009).

Similarly, Brandon et al., (2010) refer to the co-existence of parental substance misuse, parental mental ill health and family violence as the 'toxic trio', seen in the family backgrounds of a large proportion of children and young people who end up as the subjects of serious case reviews in the United Kingdom.

The Report of the Protecting Victoria's Vulnerable Children Inquiry found that families with multiple complex problems such as parental substance misuse, family violence, mental illness, intergenerational social and economic exclusion and chronic involvement with statutory child protection services, pose a major challenge for the broader system (State Government of Victoria, 2011).

Key message

Family violence, parental substance misuse and parental mental illness are associated with issues of poverty, homelessness, unemployment and isolation, which add to the difficulties experienced by the child.

In April 2012 the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) sought applications for funding under the 'Child Aware Approaches' initiative. This aims to ensure that 'the links between child abuse and neglect and domestic/family violence, mental illness, and sexual abuse are better understood and reflected in service responses for children and young people, recognising that substance abuse may intersect with these issues'.

With a growing body of evidence validating the increased complexity of vulnerable families and the need for services to work together to ensure the safety and wellbeing of children, greater understanding of the three interconnecting risk factors is needed across child and adult services. The increased complexity for families and services can be seen through an examination of the harmful consequences of family violence, parental substance misuse and parental mental illness, as single risk factors.

Child death inquiries and reviews in Australia and overseas continue to confirm the increased complexity of vulnerable families and the need for services to work together to ensure the safety and wellbeing of children.

Finding	Implications for practice
The combined presence of family violence, parental substance misuse and parental mental illness had a 'snow-ball' effect on the lives of children and families that exceeded the separate effects of each risk factor.	Risk factors cannot be considered in isolation from one another. The sum is greater than the parts and it is the impact of the whole which has to be considered in assessment and intervention.

Family violence and the developing child

Family violence is a complex phenomenon that occurs in a range of family circumstances and settings and is often associated with other risk factors. During 2010-11, Victoria Police submitted 40,892 'family incident reports' and children were present in 35% of cases attended by police (Victoria Police Crime Statistics, 2011). Children's exposure and experience of violence within the family is a major risk factor strongly associated with adverse outcomes for their development.

The *Family Violence Protection Act 2008* provides a comprehensive definition of family violence and sets out provisions to: maximise safety for children and adults who experience family violence; prevent and reduce family violence to the greatest extent possible; and promote accountability of perpetrators of family violence for their actions. This legislation provides a non-exhaustive list of examples of behaviour that constitutes family violence and includes behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of such behaviour. It is also made clear that behaviour may constitute family violence even if it would not constitute a criminal offence (State of Victoria, 2008).

Children exposed to family violence experience significant trauma and are at high risk of suffering physical harm and psychological and emotional damage. From a developmental perspective, the effects of family violence on the child depend on a range of factors such as the extent, frequency and length of exposure and whether the child was directly involved in the violence (Potito et al, 2009).

For example, by the age of two years children are reactive to their environment and have learnt to either intervene or withdraw and hide in fear. Between the ages of two to eight years children do not have the cognitive ability to fully understand family violence and may believe they are the cause or blame themselves. Between the ages of eight to 12 years children may continue to blame themselves for the violence or they may try to stop the violence and if they fail to stop the violence, they may withdraw or become aggressive and join forces with the aggressor to protect themselves. Adolescents can experience a range of emotional responses which may be expressed as anger and directed outwards as abuse, or inwards leading to withdrawal.

The impact of family violence on the developing child

Family violence increases the risk of:
■ miscarriage, stillbirth, low birth weight or infants born with complex medical issues and disabilities
■ physical injury or death when infants are directly involved, such as being held as a shield by the mother, hit by thrown objects or intentionally threatened or hurt to terrify the mother
■ insecure attachment and changes in behaviour such as irritability, sleep disturbances, more extreme 'startle' responses and more minor illnesses
■ behavioural problems, psychosomatic disorders, poor academic performance and difficulties in concentration and attention
■ homelessness and risk taking behaviours or heightened risk taking behaviours depending on the frequency and intensity of the violence

Parental substance misuse and the developing child

A significant number of children known to Child Protection live in families where parental substance misuse occurs. Children raised in such families are at risk of poor developmental outcomes. The impact on children varies depending on the type and combination

of substances used by the parents, their pattern of usage and the age and vulnerability of the child. Nonetheless, family life for these children may be characterised by chaos and unpredictability, making family structure and rules either nonexistent or inconsistent.

Children may not understand that their parents' behaviour and mood is determined by the influence of alcohol or drugs and may feel confused, insecure and responsible for their parents' substance misuse.

As a primary risk factor, parental substance misuse alone is not sufficient to trigger a Child Protection response however, it may be a contributing cause of abuse and neglect and trigger a response as a secondary factor.

The impact of parental substance misuse on the developing child

Parental substance misuse increases the risk of:
■ physical harm for the child if there is lack of parental supervision, neglect or failure to adequately child-proof the family home
■ sexual harm for the child when there is chaos, dysfunction, poor communication and blurred roles within the family
■ emotional harm for the child and may lead to the child suffering post-traumatic stress syndrome, sleep disturbances, anxiety and depression
■ family violence and heightens the risk of physical and emotional harm to the child
■ the child developing self-esteem issues, behavioural problems, poor academic performance and difficulties in concentration and attention
■ the child developing psychosomatic disorders and fears for their parents' health and wellbeing (who are at risk of illness or death as a result of their substance misuse)
■ the child developing drug and alcohol problems as they get older

Parental mental illness and the developing child

Not every parent with a mental illness has difficulties with parenting. The identification of a parent's mental illness does not inevitably lead to negative consequences for the child and protective concerns. The parent's mental illness becomes a potential risk factor when the child's family environment becomes chaotic and threatening, particularly if the child is included in the parental delusional behaviour (Rupert & Mayberry, 2007). The impact of a parent's mental illness on children will vary depending on the type and severity of the mental illness, its chronicity and the age and vulnerability of the child.

Knowing the diagnosis may be less helpful than a description of the mental health symptoms and the adult's day to day functioning. An adult may experience some mental health symptoms but not of sufficient number, severity or longevity to meet the criteria for a particular diagnosis (Commonwealth Department of Health and Aged Care, 2000). Mental health symptoms, even when not sufficient to be classified as a mental illness, may be debilitating and impact on the adult's ability to function. 'Parenting is difficult at best, but having a mental illness compounds parental stress and the ability to fulfil parental roles' (Mason & Subedi, 2006), (Mason et al., 2007, 1106). Episodic ability and inability to parent can be one of the hallmarks of some mental illnesses (Duncan & Reder, 2003; Lewin & Abdrbo, 2009).

When children have parents with a mental illness the risk of harm is associated with the parent's behaviour, not their diagnosis; these children are primarily affected by the symptoms and behaviours associated with their parent's mental illness.

The impact of parental mental illness on the developing child

Parental mental illness increases the risk of:

- emotional, physical and sexual abuse and neglect for children if parents are less able to protect their children from harm
- antenatal complications and other health problems in infancy resulting from the side effects of some medications
- social and behavioural problems in childhood and adolescence if parents have difficulty providing adequate and consistent care and appropriately responding and interacting with their children
- learning and educational problems for children if there is constant disruption and inconsistent care in the home (due to hospital admissions and medical treatment)
- children developing mental health problems later in life

4. Service system responses to multiple risk factors

Government reviews and initiatives in Australia and the United Kingdom recognise that in order to achieve positive outcomes for vulnerable children and families with multiple risk factors services need to work together. Evidence that the work carried out by one service may counteract the work carried out by another service makes the requirement for an integrated multi service response all the more essential to ensure the wellbeing and protection of vulnerable children and their families.

The principle of working together is not new and over the years there have been a number of government policy, program and practice reviews and initiatives to promote and facilitate a more cooperative and collaborative approach between Child Protection and specialist adult services. For some services working cooperatively and collaboratively is increasingly becoming the norm, however, 'good examples of working together often relies on the goodwill of individuals. Notwithstanding the best intent, legislation, policies, programs and procedures for collaborative working...to protect children...need to be intelligently and effectively applied by services' (Laming, 2009). The identification of a more collaborative approach between child and adult services is well supported through core principles underlying human rights frameworks, including the United Nations Convention on the Rights of the Child.

The United Nations Convention on the Rights of the Child (1989) provides a common framework and core principles that underpin all services and various laws and policies. When the Australian Government ratified the United Nations Convention on the Rights of the Child, it agreed to promote and protect children's rights through improving legislation, policies, programs and practice standards. The development of the National Framework is a significant example of the government's commitment to promoting and protecting children's rights.

The National Framework recognises that protecting children is a shared responsibility within families, communities, professions, services and government. The National Framework advocates a public health approach to protecting children and provides an opportunity for governments to develop strategies to achieve positive outcomes for children. One of the 12 national action

priorities under the National Framework is 'joining up service delivery', which relates to the implementation of a joined up approach to service design, planning and delivery, targeted to the hard to reach, most disadvantaged children and families.

The public health approach to protecting children is supported by research in Australia and overseas. In Australia, Emeritus Professor Dorothy Scott OAM, a public advocate of this approach, examines how adult specialist services can support children at risk of abuse and neglect in '*Think child, think family*'. Scott recognises the increasing number of 'families with complex and compounding problems' in the Child Protection population and suggests 'joining up' services so that they provide a more integrated response to families with multiple and complex needs. According to Scott, 'building the capacity of adult-focused services to be child and parent sensitive is as important as building capacity of child-focused services to be child and parent sensitive. Both are essential strategies in a national approach to protecting and enhancing the wellbeing of Australia's most vulnerable children' (Scott, 2009)

In 2006 the former Victorian Government's approach to promoting positive outcomes for children was reflected in major policy statements and the *Every child every chance* reforms across government and nongovernment sectors. The *Victorian Children's Outcome Framework* was developed to provide a common basis for setting objectives and planning across the whole of government.

Major state legislative reforms have included the *Child Wellbeing and Safety Act 2005* and the *Children, Youth and Families Act 2005*. The *Child Wellbeing and Safety Act 2005* provides an overarching framework to promote positive outcomes for all children. The *Children, Youth and Families Act 2005* provides the legal framework that guides the actions of Child Protection, family and community services in relation to vulnerable children and introduces a new focus on cumulative harm.

The *Children, Youth and Families Act 2005* states that when interpreting the provisions that determine when a child is in need of protection, 'the harm may be constituted by a single act, omission or circumstances or accumulate through a series of acts, omissions or

circumstances'. Cumulative harm is 'experienced by a child as a result of a series or pattern of harmful events and experiences that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods' (DHS, 2007).

The current Victorian Government announced the *Protecting Victoria's Vulnerable Children Inquiry* on 31 January 2011. The Inquiry was tasked with investigating systemic problems in Victoria's child protection system and making recommendations to strengthen and improve the protection and support of vulnerable young Victorians.

The Inquiry Panel presented its report to the Minister for Community Services on 27 January 2012 and it was tabled in the Victorian Parliament on 28 February 2012. The report identified ten major system reforms, the first of which refers to development of a *Vulnerable Children and Families Strategy* – a whole of government vulnerability policy framework with the objective of focusing on a child's needs (overseen by government through a Cabinet sub-committee). The report highlights the importance of working together, sharing responsibility to protect vulnerable children and proposes a more holistic framework for better responding to child abuse and neglect (State Government of Victoria, 2011).

In May 2012, the Victorian Government's directions paper *Victoria's Vulnerable Children: Our Shared Responsibility*, announced the development of a whole of government *Vulnerable Children and Families Strategy*. The paper also highlighted that significant risk factors for child abuse and neglect include parent, family or caregiver characteristics involving a history of family violence, alcohol and other substance misuse and mental health problems.

The directions paper reinforces the position that everyone has a responsibility for protecting children from abuse and neglect and that everyone needs to get involved (Government of Victoria, 2012). The paper also refers to the decision to establish a Commission for Children and Young People and to appoint a Commissioner with special responsibility for vulnerable Aboriginal children and young people and other initiatives aimed at achieving 'joined up' and strategic action across government.

Over recent years, significant policy and practice frameworks in Child Protection and specialist adult services have included:

Child Protection, family placement and support service system

Significant previous reforms included legislative changes through the *Children, Youth and Families Act 2005* and the *Child Wellbeing and Safety Act 2005*. The Best Interests framework was developed to support a consistent understanding and application of the principles and key provisions of the *Children, Youth and Families Act 2005*, across Child Protection services, family services and placement and support services.

In 2010 several specialist practice resources were developed for Child Protection practitioners and a resource about working with parents with multiple and complex needs has recently been published. More recent DHS initiatives include *One DHS organisational review* and *Human Services; the case for change* which promote a more integrated approach to service delivery.

The recently introduced *Services Connect* model aims to reform the human services system to deliver more effective and integrated services.

Family violence service system

There has been a significant shift towards an integrated family violence service system and the development of a common framework to effectively identify and respond to victims of family violence for all service providers.

Central to the reforms was the legislative change through the *Family Violence Protection Act 2008*, and the strengthening of police responses through the *Code of Practice for the Investigation of Family Violence (2004 and 2010)*. Within Victoria Police there are dedicated Family Violence Advisors and Liaison Officers as well as response teams to deal with family violence matters.

In early 2012 the Victorian Government initiated the development of a three-year action plan *Addressing Violence against Women and their Children* and a period of consultation has been completed. The aim is to make Victoria a place in which women and their children can live free from violence by strengthening an integrated

approach to prevention, early intervention and response to gender-based violence against women and children.

Alcohol and drug service system

In 2005 the *Parenting support toolkit for alcohol and other drug workers* resource was produced by the Victorian Parenting Centre and Odyssey House Victoria, with funding from the Department of Human Services and the Department of Health to help workers in this sector address the vital role that parenting plays in their clients' lives. Another initiative is the *Kids in Focus* specialist child and family support program run by Odyssey House that provides a range of intensive services to families affected by parental alcohol and other drug problems.

In 2010 the Victorian Alcohol and Drug Association arranged a series of state-wide forums which brought together a range of agencies involved with vulnerable families and their parents to consider how best to collaborate to effectively include children at risk in their work.

A *Whole of Government Victorian Alcohol and Drug Strategy* is being developed to address and reduce the rate of alcohol and drug abuse and the amount of harm it causes in the community and to increase treatment options. Following public submissions and a consultation process, a report from the project's community engagement forum was produced in 2012 which identified key themes; one of which was the lack of service coordination and the 'silo' approach of agencies.

In May 2012, the Australian Drug Foundation presented a *DrugInfo* seminar on *Responding to the needs of children and parents in families experiencing alcohol and other drug problems*.

Mental health service system

Major reforms have included a whole of government mental health approach. The *Because mental health matters: Victorian mental health strategy 2009–2019* was introduced to facilitate collaboration between service providers. One of the reform areas included the provision of 'proactive support to families where mental health problems may be damaging family relationships

and putting children at risk. This will connect mental health and alcohol and drug treatment services with Child FIRST sites so that family support interventions are provided when required' (DHS, 2009).

Families where a parent has a mental illness: A service development strategy (DHS, 2007) assisted services to develop more coordinated and effective approaches to address the heightened risk of vulnerable families and in particular, those families not accessing supports. This initiative aimed to increase the capacity of specialist mental health services to respond effectively to the parenting needs of their clients and will be evaluated in the near future. The *Families and Mental Health Parenting; A Resource Kit* (Department of Health, 2011) was developed for parents who are clients of the public mental health service system.

The Victorian *Mental Health Act 1986* provides a legislative framework for the care, treatment and protection of people with mental illness in Victoria and is currently being reviewed. In the bill being drafted to revise policy for a new Act, the Secretary of the Department of Health (DoH) will have a role in promoting co-operation between different mental health services and other providers of services for people who have a mental illness.

In 2012 the Community Mental Health Planning and Service Coordination (CMHPSC) initiative began engaging a range of agencies to improve mental health outcomes for local populations. Cross-sector mental health planning and coordination partnerships have been established in each DoH Region.

Interdepartmental initiatives

A partnership plan has been developed between the DoH Mental Health, Drugs and Regions Division and the DHS Children, Youth and Families Division. An interdepartmental memorandum of understanding was signed in 2009, pledging a commitment to collaborative efforts to improve outcomes for vulnerable children and their families.

Key message

Continued attention needs to be given to individual and shared policy development across each of the sectors regarding collaboration about the role of parenting and assuming responsibility for children's wellbeing and safety.

Service systems integration

Effective collaboration between services is known to lead to positive outcomes; to achieve positive outcomes for children and their families' child and adult services need to work together.

Morrison (1996, p.129) stated that 'because the management of Child Protection requires the combined skills and resources of different agencies working together, then the quality of interagency collaboration has a direct impact on partnerships between agencies and families. Partnership is about services sharing information, accountability, and communication. Rather like the child whose world is mediated through the quality of the relationships between the parents, so the experience of vulnerable families in the Child Protection process is mediated through the modelling of multidisciplinary relationships and behaviour.'

Hallett and Birchall (1992) as cited by Morrison (1996), suggest that collaboration is when the combination of skills leads to an outcome which would not otherwise be achieved as effectively or efficiently by other means. 'Collaboration helps define relationships, so that positive results are more likely to be achieved by working together rather than alone. Each organisation brings its own unique contribution and function to a joint effort, while continuing to provide individual services.' (DHS, 2004).

Veysey and colleagues (2004) argued that integrated services for persons with co-occurring problems have better results compared to parallel or sequential services. They contend therefore, that integration is needed at both a systems and service level.

A small number of programs were found that explicitly respond to these co-occurring risk factors of family

violence, parental substance misuse and parental mental illness. The number of programs increases when looking at two of these factors and increases again when looking at one of these risk factors in terms of parenting. Most child and family services, family violence, alcohol and other drug services and mental health services are already working with many of these complex families, whether or not they have been designed to do so.

Key message

Professionals in all fields need to be supported in managing risk factors associated with family violence, parental substance misuse and parental mental illness to prevent oversimplification of issues and becoming overwhelmed by the complexity of the cases.

Regardless of whether focused on one, two or three risk factors, if the service response recognises the multiple risk factors, (including those not directly targeted) and applies best practice principles, it will be more able to meet the multiple and complex needs of these children and their families.

Assessing parenting capacity

The assessment of parenting capacity is an important aspect of Child Protection work that can have a significant impact on outcomes for children. These assessments assist in identifying parental strengths and needs in order to determine service provision for families and inform key decisions. For children, these assessments are crucial in protecting them from risk and enhancing their developmental experiences, as well as informing decisions about removing and/or restoring children to the care of their parents (New South Wales Department of Community Services, 2005).

Key message

When multiple parental risk factors co-exist, the assessment process needs to consider the complexity of each risk factor from an historical perspective and understand how they interrelate.

When assessing parents presenting with multiple risk factors associated with issues of family violence, substance misuse and mental illness, developing an understanding of their life experiences and their ability to manage their life with or without supports is critical.

Key message

Episodic and volatile patterns of behaviour can occur in parents experiencing the three identified risk factors and the cumulative impact of this unpredictable environment on children must be considered in assessment and planning processes.

The way in which different services build a picture of the parents' capacity to parent a particular child is also critical. The views held by services can have implications for intervening early, assisting the parent's motivation to change and preventing the escalation of issues. Dale and Fellows (1999) contend that the parenting assessment process itself can support change and be therapeutic for both the parent and the child.

How services build a picture of the parents' capacity to parent depends on factors that include theoretical

orientation and framework. Despite the range of different parenting assessment frameworks available, some of the more common elements include considering:

- the standard of parenting provided to the child within the appropriate cultural context and whether it would be considered 'good enough' parenting
- the quality of the parent-child interaction through interviews and direct observations in the family's natural setting over time
- the parent and child's individual family experiences ascertained through separate interviews (particularly if there are concerns regarding family violence)
- an ecological perspective to assist with understanding intergenerational issues and factors that influence family function and dysfunction.

Key message

Family violence, parental substance misuse and parental mental illness are risk factors that can compromise a parent's cognitive processes and ability to make sound decisions for their child and respond to them appropriately in a crisis situation.

5. The children and their families

The circumstances precipitating the report to Child Protection were different for each of the children. Despite these differences however, the process of inquiry that occurred after the death of each child found the same three parental risk factors present in the cases.

An overview of the children and their families is provided below. Information about the cases has been generalised

where necessary, to prevent the child and family being potentially identifiable from the combination of characteristics provided.

Six of the cases involved Aboriginal children or young people.

Table 5.1: The children (N=41)

Case No.	Age at death	Gender	Category of death	Stage of Child Protection involvement
1	2 days	Female	Acquired illness	Open/Investigation
2	2 days	Female	Acquired illness	Open/Intake
3	8 days	Male	Unascertained	Open/Protective Intervention
4	9 days	Female	Unascertained	Open/Investigation
5	4 weeks	Female	Acquired illness	Open/Investigation
6	4 weeks	Female	SIDS	Open/Protective Intervention
7	1 month	Male	Acquired illness	Open/Investigation
8	2 months	Male	Unascertained	Open/Protective Intervention (IAO)
9	2 months	Male	SIDS	Open/Investigation
10	2 months	Male	SIDS	Closed
11	2 months	Male	Acquired illness	Open/Investigation
12	2 months	Female	Acquired illness	Open/Investigation
13	3 months	Male	Acquired illness	Open/Protective Intervention
14	4 months	Male	Acquired illness	Closed
15	5 months	Male	Unascertained	Open/Investigation
16	6 months	Male	SIDS	Closed/Investigation
17	8 months	Male	SIDS	Open/Protective Intervention
18	9 months	Male	SIDS	Open/Investigation
19	1 year	Female	Acquired illness	Open/Protective Intervention
20	1 year	Male	Non-accidental trauma	Open/Protective Intervention (IAO)
21	1 year	Female	Unascertained	Closed
22	1 year	Female	Acquired illness	Open/Custody to the Secretary Order
23	1 year	Male	Acquired illness	Closed
24	2 years	Male	Unascertained	Closed
25	2 years	Male	Accident	Closed

Case No.	Age at death	Gender	Category of death	Stage of Child Protection involvement
26	3 years	Female	Unascertained	Closed
27	3 years	Male	Unascertained	Closed
28	4 years	Male	Acquired illness	Closed
29	4 years	Male	Accident	Open/Intake
30	4 years	Male	Accident	Open/Supervised Custody Order
31	4 years	Male	Accident	Open/Investigation
32	5 years	Male	Acquired illness	Closed
33	13 years	Male	Accident	Open/Investigation
34	14 years	Female	Suicide	Open/Custody to Secretary Order
35	14 years	Male	Suicide	Closed
36	15 years	Male	Drug related	Closed
37	15 years	Male	Accident	Open/Guardianship to the Secretary Order
38	15 years	Female	Accident	Open/Investigation
39	15 years	Female	Drug related	Open/Custody to Secretary Order
40	16 years	Female	Drug related	Open/Custody to the Secretary Order
41	16 years	Male	Drug related	Open/ Custody to Secretary Order

Table 5.1 profiles the children chronologically from youngest to oldest and shows their age, gender, category of death and the stage of Child Protection involvement at the time of their death:

- The children's deaths occurred between December 2004 and March 2011.
- The children ranged in age from two days to 16 years.
- 27 of the children were aged from birth to three years.
- Five of the children were pre-school age; of these four were 4 years, and the five year old had not yet started school.
- Nine were young people in their adolescent years (13–16).
- Twenty-seven of the children were male and 14 were female.
- Causes of death for the children were attributed to a range of factors.
- More than half (28) of the children had open Child Protection cases: two in intake; 12 in investigation; seven in protective intervention and; seven in protective order phase.
- The protective order phase involved five adolescents subject to Children's Court Orders: one was on a Guardianship to the Secretary Order, and four were on Custody to Secretary Orders.

Table 5.2: Category of death by age (N=41)

Category of death	Birth–3 years	4–12 years	13–17 years	Total	%
Accident	1	3	3	7	17
Acquired illness	11	2	-	13	32
Drug related	-	-	4	4	10
Non-accidental trauma	1	-	-	1	2
SIDS	6	-	-	6	15
Suicide	-	-	2	2	4
Unascertained	8	-	-	8	20
Total	27	5	9	41	100%

The Office of the Child Safety Commissioner categorises each child death based on information received from the Department of Human Services and the Coroners Court Victoria. Table 5.2 shows the death categories according to three age groupings.

- Of the 27 infants in the birth to 3 years category one death was due to non-accidental trauma, one death was due to accidental causes; 11 deaths were due to acquired illness; six deaths were attributed to sudden infant death syndrome; and eight deaths were deemed to be unascertainable by the coroner.

- Of the five children in the 4 to 12 years age group: two deaths were due to acquired illness; three deaths were due to accident.
- Of the nine adolescents in the analysis cohort three deaths were due to accident; two deaths were the result of suicide; and four deaths were drug-related.

Table 5.3: Number of children in family (N=41)

Number of children in family	Total
Only child	5
Two children	10
Three children	8
Four children	7
Five children	5
Six children	5
Seven children	1
Total	41

Table 5.3 shows the number of children in the family. The majority (36) of the children had at least one sibling. The children's family relationships were complex and unpredictable. The children were exposed to constantly changing family structures resulting from multiple parental partners. Some infants had older siblings with extensive Child Protection histories. The siblings' histories provided a significant source of information about the likelihood of risk for the infants subject to the analysis. On occasion this history was the only source of information available.

* Siblings include full and half-siblings (and step-siblings if it appears child lived with them at some stage)

Table 5.4: Birth order of children (N=41)

Birth order	Total
Youngest in family	24
Oldest in family	6
Middle child	6
Only child	5
Total	41

Table 5.4 shows the children's birth order in the family. The majority (24) of the children were the youngest in the family.

Table 5.5: Care arrangements of children (N=41)

Care arrangements	Infant	Pre-school	Adolescent	Total
Living with parent/s	19	4	4	27
Living with parent/s and extended family	2	-	-	2
Living in out-of-home care (kinship care)	1	1	2	4
Living in out-of-home care (residential care)	1	-	2	3
Did not leave hospital	5	-	-	5
Total	28	5	8	41

Table 5.5 shows the children's care arrangements at the time of their death. The majority (29) of the children were living at home in the care of one or two parents; this included two children who, although in the parent/s care, initially lived with extended family. Seven children were living in out-of-home care: of these four were living with extended family through the kinship care program and three children were in residential care.

Placing children in out-of-home care with extended family did not necessarily remove the likelihood of risk to the child. A small number of children placed with extended family continued to be exposed to unresolved family issues due to the nature of the familial relationship between the biological parents and the family carer. Examples included a family member who declined to care for a child because of fear of the father; another family carer who requested that the placement be undisclosed; and family carers with their own reported mental health and alcohol and drug issues.

Figure 5.1: Child Protection history (age of child by Child Protection reports and level of Child Protection involvement)

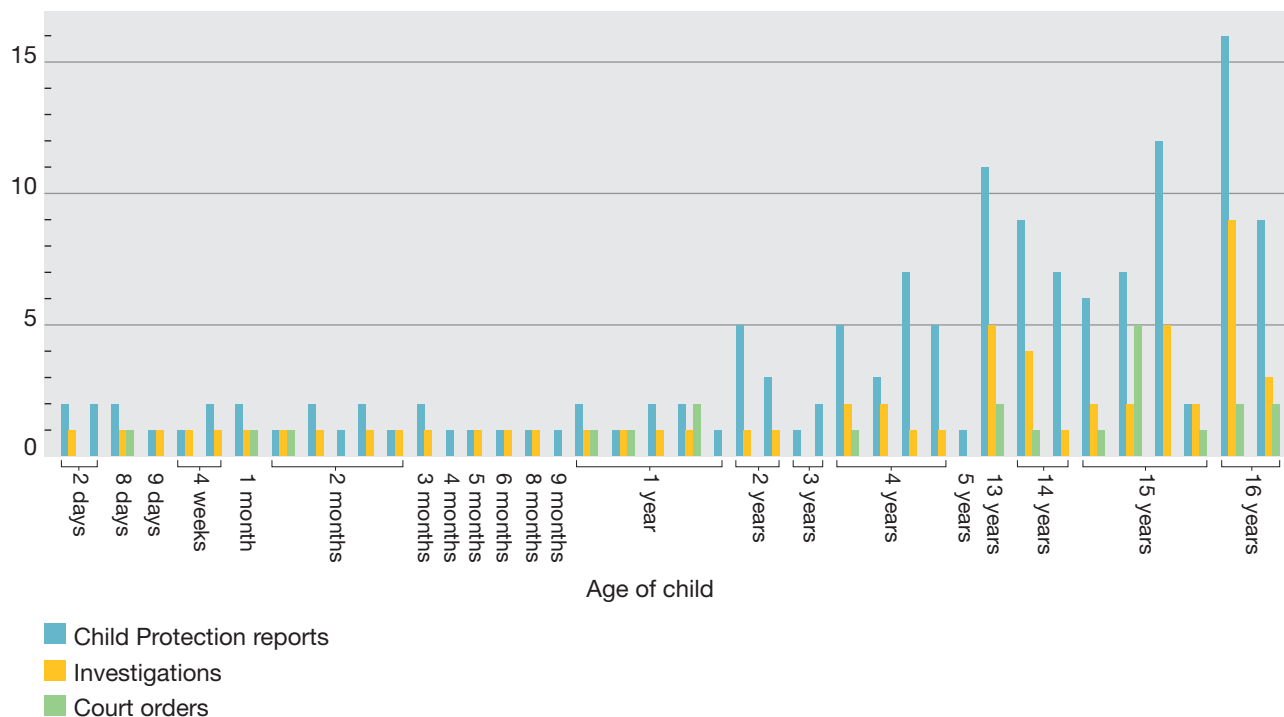


Figure 5.1 shows that 26 of the 41 children were subject to more than one Child Protection report. Eleven of these children were also subject to an unborn child report due to the identification of risk factors during the mother's pregnancy. The figure also shows that the number of Child Protection reports increased with the child's age. A small number of children had been reported to Child Protection authorities in other interstate jurisdictions. When combined, a total of 145 reports were received by Child Protection in relation to the 41 children and of these less than half (59) of the reports proceeded to investigation and even fewer (22) resulted in Children's Court orders.

Table 5.6: Intergenerational patterns of harm (N=41)

The parent/s' childhood experience of:	Total
Child Protection involvement – confirmed	11
Child Protection involvement – inferred	8
Abuse (sexual/physical/emotional) and/or neglect	18
Out of home care	9
Sexual abuse in out-of-home care	2
Youth justice	4
Adoption	3
Family violence	14
Parental substance misuse	10
Parental mental illness	2

Table 5.6 shows that the experience of Child Protection involvement was not limited to the children. Many of the parents of the children were also known to have experienced a background of abuse and neglect and for some, this resulted in Child Protection involvement during their childhood and adolescent years.

Discussion regarding parental risk factors

A qualitative analysis of the 41 child deaths identified themes and issues that continue to be the subject of government reforms across Child Protection and specialist adult service systems. The report found that even though the 41 Child Protection cases presented with issues associated with family violence, parental substance misuse and parental mental illness, the level and intensity of involvement by Child Protection and relevant specialist adult services was highly variable. Not all of these issues were consistently addressed and responded to by the services involved.

The issues raised by the cases remained consistent over the 2004-2011 period of time.

Findings	Implications for practice
Multiple risk factors appeared to be minimised by both families and professionals.	Underestimating the impact of parental risk factors is not acting in the child's best interests.
The majority of the children came from families with repeated risk factors.	Intergenerational issues of practices resulting in poor parenting can reduce the availability of extended family members who can appropriately care for children.
A tendency to divide people's difficulties into symptoms that required a separate response was evident in these cases.	Purposeful communication between services, timely case conferences, effective planning and case management are essential in cases where multiple services are involved.

Themes relating to family violence

Key message

Children exposed to family violence experience significant trauma and are at high risk of suffering physical harm and psychological and emotional trauma.

There was a high level of volatility within the children's families, which included verbal arguments and fighting. The high level of volatility was not limited to the family home; it had also occurred in the general community and in the presence of professionals in hospitals, Child Protection offices and in phone calls with Child Protection workers. Examples included a parent being admitted to psychiatric care for an extensive period due to committing violent crimes against others outside the family and involving the use of weapons; threats of violence by fathers to professionals and a father being denied admission to a parenting assessment unit due to his history of violence.

The experience of violence was different for men and women. Violence carried out by men towards women was often part of a pattern of behaviour ranging from life-threatening physical assaults to threats and intimidation. Violence carried out by women was often in response to the violence, threats and intimidation by men and on occasion, when a mother was mentally unwell.

Key message

A mother who is a victim of family violence may experience impaired cognitive and emotional functioning. This can increase the risk of child abuse and requires comprehensive assessment and targeted intervention.

The women's experience of violence was not confined to one relationship, with women experiencing violence across multiple relationships. Leaving the violent partner was not always sufficient to ensure the women's and children's safety; violence tended to continue post separation. In several cases, the mother left the violent father and then returned. The reasons for returning to live with the violent partner were mixed and included fear of reprisal, not wanting to be homeless, and stating it was better for the children. For example, *'the only reason why I've let him back into my life after the last four Intervention Orders was because of the kids and that he'd promised to treat me right and that it wouldn't happen again.'*

Men and women tended to minimise the extent of the violence and the children's exposure to the violence. Men were noted to have said: *'I'm not violent, I just slapped her face ... It isn't happening, she lies ... I need to discipline her ... I only hit her as a last resort'*.

There were severe consequences of the violence for women and children, whereas the consequences for perpetrators were less apparent. The women experienced a range of physical, psychological and social problems as a direct result of the violence which included being hospitalised, leaving the family home, becoming homeless, suffering physical injuries and post traumatic stress disorder and feeling unable to cope with the children. The children experienced feelings of fear and a sense of powerlessness, for example one child stated that she was *'upset, scared and cried and thought my dad would bash mum up'*. These feelings were further compounded by their exposure to police intervention, separation from their mother during hospitalisation and uncertainty about their family's future.

Key message

Addressing the impacts of the violence on women and children and providing parenting support can significantly contribute to children's wellbeing and safety.

Themes relating to parental substance misuse

Key message

The impact of parental substance misuse on children will vary depending on the type and combination of substances, the pattern of usage and the age and vulnerability of the child.

Children often had more than one significant adult in their life with issues of substance misuse. Many of the children had at least one parent who misused multiple substances. In some cases, the consequences of the parents' substance misuse were severe for both the

parent and the child. Substance misuse during the mother's pregnancy was not uncommon in these cases and some infants experienced drug withdrawal at birth. At times parental substance misuse resulted in drug overdoses and on occasion, death.

Table 5.7: Types of substances used by one or more parent/carer

Types of substances used by one or more parent/carer (N=41)	
Cannabis	33
Alcohol	27
Amphetamines (speed, ecstasy, ice, cocaine)	17
Heroin	12
Methadone	5
Other opiates	3
Benzodiazepines	7
Prescription medication over use/combined with illicit drugs	4
Inhalants	2

Parental substance misuse behaviours included episodic, bingeing, daily use and chronic longer term use. The analysis found that:

- there was a high prevalence of cannabis and alcohol abuse in these cases
- the majority of children had at least one parent with problematic use of more than one substance; polydrug use was evident in a high proportion of cases
- some parents obtained prescriptions from more than one doctor
- problematic substance use was not always identified despite clear indicators, such as being apprehended for driving under the influence of alcohol or drugs
- some parents tended to deny or minimise the extent and impact of their substance use, such as claiming that their long history of drug use had made them immune to its effects.

The pattern and history of parental substance misuse was not always known, although commencing drug use in adolescence was not unusual. Parental substance misuse at times was in response to significant trauma and there was evidence that it was likely to have been in part an attempt to manage overwhelming feelings associated with trauma, grief and loss.

Key message

The impact of parental substance misuse on children's health and development is significant and can range from experiencing to witnessing high levels of violence, abuse and neglectful parenting.

Parental substance misuse was found to be associated with a range of issues including:

- mental health – for example some parents were diagnosed with psychosis which apparently was considered to be induced or exacerbated by drug use
- relationship breakdown – separation occurring due to concerns about a partner's substance misuse
- criminal activity, imprisonment, a heightened risk of violence, unpredictable or dangerous behaviours including paranoia
- inadequate parenting due to parents' pre-occupation with obtaining and using substances at the risk of ensuring their children's need for care and protection – for example a parent falling asleep while drug affected and caring for an infant
- heightened risk of child substance misuse – passive inhaling of cannabis smoke
- heightened risk of medical complications at birth – infants of substance abusing mothers were sometimes born prematurely with low birth weight and drug dependant
- in almost half of the cases the mothers of infants were known to use alcohol or other drugs in pregnancy, on occasion resulting in an overdose during pregnancy.

Finding	Implications for practice
The combinations of drugs and alcohol used by parents often did not appear to be adequately explored, nor was advice sought from this sector about the potential for impaired parenting capacity and the impact on children.	There is value in seeking consultation and learning from the expertise of drug and alcohol treatment services as part of effective collaboration.

Themes relating to parental mental illness

Key message

The impact of parental mental illness on children will vary depending on the type and severity of the mental illness, its chronicity and the age and vulnerability of the child.

It was not always clear if the parents' mental illness had been diagnosed, or whether there had been a formal mental health assessment. However, it was evident that parents exhibited concerning symptoms that impacted on their parenting capacity and their children's lives.

Mental health issues were not usually confined to any one family member. Many of the adults in the children's lives had some degree of mental health issues, ranging from a cluster of vaguely described symptoms to specific diagnosis of serious mental illness:

- in cases where parents had a long history of mental health problems there were often multiple diagnoses. These were often listed by Child Protection workers, but with little demonstrated understanding of the meaning or impact of these on parental functioning, nor on how the children may actually experience their parents' ill health on a daily basis
- the diagnosis or formulation was not always clear and sometimes changing. This did not appear to be a differential diagnosis, but rather arose from various mental health professionals giving different advice

over time or from self-reports by parents about their diagnoses

- mental health diagnoses included schizophrenia, bipolar disorder, borderline personality disorder, post-traumatic stress disorder, depression and postpartum depression. Symptoms included psychosis, paranoia, grandiose thinking, mood swings, lethargy, anxiety states, confused state, affect dysregulation, violence, suicidal ideation, self-harming behaviours and avoidance.

Key message

When a parent has been diagnosed with a mental illness, the risk of harm to the child is associated with the parent's behaviour and not their diagnosis.

Children were exposed to their parents' mental health issues in many ways. Examples include a father who was not compliant with his medication who talked frequently about the world ending; a mother who was also a victim of violence who threatened to harm her children and a mother who put her infant at risk while trying to escape from the police, before she was placed involuntarily in a psychiatric hospital. The infant suffered minor physical injuries, but no discussion of the emotional impact of this experience on the infant was recorded in the case file.

There was a significant lack of understanding about the impact of the parents' mental health issues on the children. When the parents were preoccupied with their own chaos they were less able to protect the child from their own symptoms and from other sources of harm. For example, a mother who had a particularly traumatic history was constantly focused on herself and unable to differentiate the child's needs from her own. As a result she frequently put the child in danger, with little demonstrated empathy for the child or understanding of the parenting role. The cases demonstrated the unpredictability and uncertainty of many of these children's lives as a result of the parents' erratic behaviour and mood swings.

Case practice did not adequately recognise the link between the children's chaotic lifestyle and the child's compromised ability to develop secure attachments.

The impact of the parental risk factors became apparent when several adolescents also required assistance from mental health services.

Finding	Implications for practice
The impact of a parent's formal diagnosis with a mental illness on their functioning and on the children's experience in the family was often not well understood by Child Protection.	The exchange of information between Child Protection and specialist adult services needs to be clear and directed at understanding the protective issues for the child.

Evidence of social and economic disadvantage

The three parental risk factors commonly coincided with economic and social disadvantage. In addition to the risk factors associated with family violence, parental substance misuse and parental mental illness, the children's families experienced additional risk factors associated with poverty, disruption, homelessness, unemployment, financial difficulties and social isolation. Housing was frequently identified as a significant issue. Some women and children became homeless trying to escape violence. Consequently, children did not only leave their home and belongings, they left friends and schools which exacerbated their family's isolation and dislocation.

Finding	Implications for practice
All families had different levels of risk associated with poverty and many had concerns regarding transience, housing and unemployment.	The impact of poverty on the parents and the child and the significance of these additional stressors on family functioning need to be understood by professionals.

Few of the families had the strong support of extended family, who at times felt overwhelmed by their support role. The absence of informal supports often meant that the services focused their attention on establishing support, such as providing child care for respite

purposes which distracted the services from addressing the underlying parental issues.

Evidence of intergenerational issues of abuse

Intergenerational issues of risk were evident in the cases considered. The children's parents generally had been exposed to a similar range of risk factors during their early childhood and adolescent years and in particular, inter-generational risk factors associated with family violence, parental substance misuse and parental mental illness were evident in the study cohort.

The analysis found parents' histories contained a range of risk factors associated with patterns of harm detailed in table 5.6.

The impact of parent-based risk factors on the developing child

Key message

Child, family and specialist adult services together need to discuss the three parental risk factors and assess the impact of these on parenting and the child.

The presence of multiple and complex parent-related issues meant that the focus of attention by services was often on the parents, in particular the women and their immediate crises. There was little information recorded about the men and the direct or indirect impacts on the children.

Finding	Implications for practice
The majority of the children came from complex, changing family structures, where it was not always clear to professionals whether the father was living with the family and/or the nature of the sibling relationships.	Assessment needs to incorporate different aspects of family structures and functioning and recognise the dynamic structures and membership in many of these families.

There was little effective service engagement apparent with the families, even over lengthy periods of involvement. There had been insufficient contact by services with the children and their developmental needs were not adequately understood. The impacts on the children tended to become apparent as high-risk behaviours demanded intervention. By the time the children reached adolescence, the cumulative effects of their experiences were difficult to ignore and called for a more thorough understanding of their origin.

Finding	Implications for practice
The cases did not demonstrate meaningful engagement with individual family members by all service providers.	To conduct a holistic family assessment, workers need to engage and assess all family members and conduct age-appropriate assessments of the children.

A common characteristic identified across the cases was one parent's incapacity to mediate the traumatic and developmental impacts of the other parent's difficulties, often due to both parents experiencing similar issues.

The impact of the three parental risk factors and services response to these largely depended on the age and stage of the child's development. With regard to the infant cases, the focus appeared to be on the parents and in particular, the mother. The pre-school aged children appeared to be largely invisible and were often considered as part of the sibling group. The adolescents in the study cohort manifested significant symptomatic behaviours which became the focus of attention by services, with little effective intervention evident with parents or extended family.

Finding	Implications for practice
In all the cases considered, parental risk factors impacted on the quality of children's lives.	The combination of risk factors should be given specific attention, not only in terms of cumulative harm, but also exponential risk.

The infants (birth–3 years)

There is an increasing awareness of the need to develop further understanding of the impact of pre-natal exposure to alcohol, drugs and violence and what this means for the child's immediate and long term health, development and wellbeing. Pre-natal exposure to alcohol, drugs and violence has been linked to adverse outcomes for children. Heavy pre-natal alcohol and drug exposure can severely affect the physical and neurobehavioral development of a child. Research on the outcomes of alcohol and drug-exposed children has shown elevated developmental risks from the interaction of subtle biological vulnerabilities and compromised parenting.

Pregnancies were often unplanned and most mothers had poor pre-natal care, with infants experiencing pre-natal exposure to alcohol, drugs and/or violence. Infant characteristics included being born preterm, drug affected and with complex medical issues. Post-natally infants continued to experience exposure to family violence, parental substance misuse and for some infants, this included passive inhalation of cannabis smoke or parental care affected by mental illness such as depression.

Finding	Implications for practice
Intensity of service involvement with vulnerable parents was low for parents of infants across all service types.	Engagement of all relevant service sectors is essential for effective early intervention strategies.

Vulnerable infants were in the care of vulnerable mothers who were poorly prepared for the task of parenting and were at risk of hindering bonding and attachment between mother and child. In relation to maternal depression, negative child impacts have been observed in measures of language development and intelligence; behaviour, including both conduct and depressive symptoms and disorders; physical ill health; the parent/child relationship and attachment behaviours, (Smith, 2004).

Finding	Implications for practice
The presence of the three parental risk factors was associated with multiple types of maltreatment.	It is important to carefully consider the impact of these conditions on parental behaviour.

The pre-school aged children (4–5 years)

The health and developmental consequences for the pre-school aged children exposed to the three parental risk factors were significant, particularly in relation to behaviour and learning. The needs of young children in this age group tended to be overlooked, as they appeared to have less interaction with formal services. Consequently, physical and emotional developmental issues may have seemed less obvious, without careful observation and assessment.

Finding	Implications for practice
Children were rarely engaged directly, asked for information, or their opinions sought on their experience in the family.	The importance of working directly with children has been highlighted in relevant research and needs to be more widely implemented.

Parents with a mental illness may have difficulty controlling their emotions, they can be withdrawn or unresponsive, overly critical, inconsistent, disorganised, lack in energy and be inward-looking, which can be at the expense of the child (Bromfield, 2010). The young children in the group analysis were subject to multiple Child Protection reports due to issues of neglect and inadequate parenting. The children were involved with fewer services and were no longer under the attention of the maternal and child health service and had not yet started primary school. The lack of sufficient service contact meant that the developmental needs of these young children were not well understood and may not have been appropriately met.

The adolescents (13–16 years)

When a child's life experiences have been characterised by issues of family violence, parental substance misuse

and parental mental illness, the cumulative impact is enormous. There is evidence that:

- without an attuned and available adult to mediate the effects of all three factors, children are at risk of abuse and neglect
- without timely and effective intervention, children are at risk of developing patterns of behaviour that parallel their parents' difficulties.

By the time children reach adolescence, their own high-risk behaviours will often demand intervention, as services are confronted with the cumulative effects of earlier abuse and neglect.

Finding	Implications for practice
If a child grows up in an environment characterised by family violence, parental substance misuse and parental mental illness, there is an increased risk of the child developing similar issues in their adult life.	All services have a significant role in working towards achieving positive outcomes for the next generation of vulnerable children.

The adolescents had histories of multiple Child Protection reports. Issues for these young people included mental health problems, substance misuse, challenging behaviour and family conflict. The response provided by services in the adolescent cases was characterised by inadequate and episodic early intervention in their lives by Child Protection. The absence of stable, secure and consistent care for these young people was evident from early childhood through to their adolescence.

The absence of a significant and supportive adult was evident after the children reached adolescence. Even when the young people's most enduring relationship was with their mother, this relationship was frequently characterised by volatility and unresolved grief. The mothers' parenting was severely compromised by their own issues of violence, substance misuse and mental illness. Unlike the mother-child relationship, the father-child relationship generally appeared to be more distant. Despite the existence of longstanding family conflicts, the focus of intervention by services was in responding

to these young people's high-risk behaviours, which included criminal activities, violence, substance misuse and sexual exploitation.

Finding	Implications for practice
The cumulative effects of the three parental risk factors on children went beyond immediate safety issues and impacted on the child across all developmental stages.	Timely intervention is required to deal with the cumulative effects of the three parental risk factors on children and their differential impacts.

Child Protection case practice

There was little evidence to support the existence of a systemic, proactive and collaborative approach to case practice by Child Protection. Not all children had a case worker assigned to work with them and some families experienced extensive periods on waiting lists, while for others, high staff turnover resulted in them having multiple workers involved.

Child Protection case assessment and planning generally lacked comprehensiveness, which meant that parental issues of family violence, substance misuse and mental illness were not given the weighting necessary to accurately assess the level of risk they posed to the child.

Finding	Implications for practice
Child Protection practice required quality information gathering, meaningful analysis of information, carefully targeted interventions and an ongoing process of critical reflection in order to be effective.	These are critical processes essential for everyday practice and coordination between services involved in partnerships of care directed at supporting vulnerable children and families.

When parental risk factors were identified, specialist adult services were not always routinely engaged and therefore the impact on parenting and the consequences for the child were not fully recognised by services. When specialist adult services were identified by Child

Protection, there was a tendency to respond to each issue separately, leading to the involvement of multiple services without a well coordinated approach.

Finding	Implications for practice
Both child and adult services required an inclusive child-parent focus.	A paradigm shift is required so that both child and adult sectors take a child and family focus and adopt a 'think child, think family' approach.

The involvement of multiple services tended to result in a lack of clarity about roles and responsibilities for both family members and the professionals involved. Case practice appeared to occur at a pace and in a volume that was not conducive to reflection and review.

Not all relevant information was referred to during case reviews. Assessments were sometimes found to remain essentially unchanged, despite the receipt of new information. It was not unusual for assessments of parents to appear overly optimistic, despite a long history of severe dysfunction within the family.

Finding	Implications for practice
Most of the children had more than one parent figure with one (or more) of the identified parental risk factors present.	When this occurs, the child has less likelihood of having a parent who is able to ensure their safety and development.

6. Evidence of a multi-service system response

Intervention to support and protect children requires a multi-service system response to match the multi-layered problems they experience.

Of the 41 cases considered in the group analysis, case notes recorded that 25 were known to have had involvement with adult services. The level of specialist adult service involvement with the remaining cases was unable to be established from the available Child Protection case material.

The analysis found little evidence of an integrated multi-service response across the 25 cases. The presence of parental risk factors did not necessarily result in referrals and engagement with specialist adult services. Parental risk factors were not always aligned with relevant adult services and in the few cases where this did occur, there was an absence of a collaborative and synchronous interaction between Child Protection, family violence, drugs and alcohol and mental health services.

Figure 6.1 shows 25 of the 41 cases were known to have had specialist adult services involvement.

Of these 25 cases, 11 had the involvement of more than one specialist adult service, seven cases had the involvement of two services and four cases had the involvement of all three services.

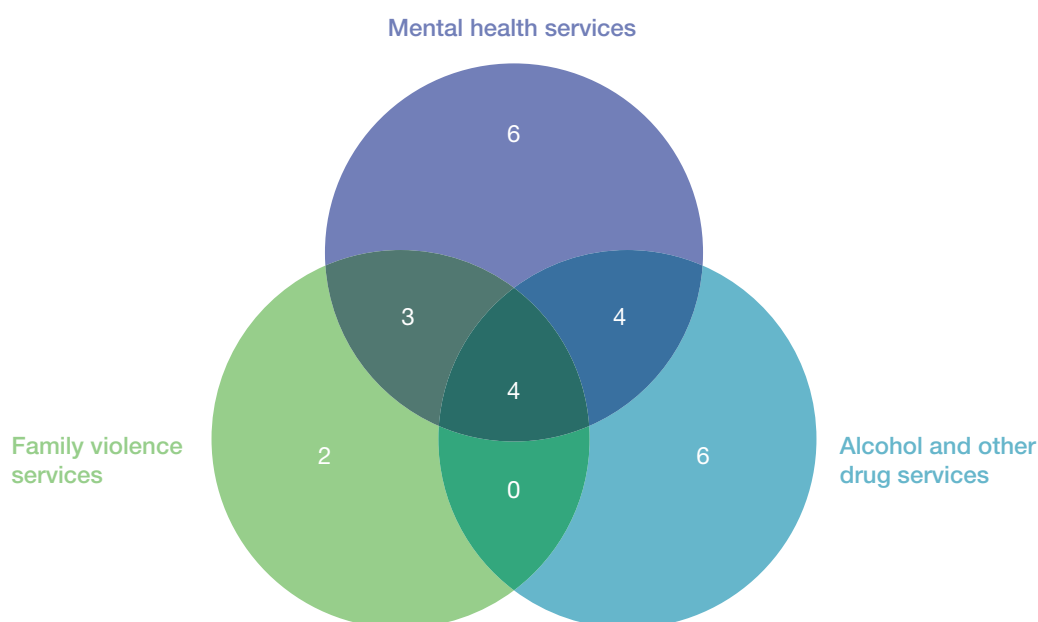
Mental health services

Of the 25 cases known to have been involved with adult services, 17 had mental health services involvement. The extent of mental health services involvement was variable across the cases, consisting of episodic involvement and/or continuous involvement.

The mental health services provided included private and public psychiatric services (voluntary and involuntary), community mental health services, hospital mother-baby services and crisis assessment and treatment services. The services provided ranged from one-off assessments, crisis assessment and treatment, and psychiatric treatment to episodic involvement with varying degrees of intensity and long-term involvement, which included involuntary psychiatric hospitalisation.

At times there was minimal mental health services involvement, as it was assessed that the issues were primarily drug and alcohol related. For example, some referrals made to mental health services were not accepted on the grounds that parents were not following through with their issues, which were perceived as essentially drug and alcohol related.

Figure 6.1: Child Protection cases with multiple adult services involvement (N=25)



Alcohol and other drug services

Of the 25 cases known to have had involvement with adult services, 14 had alcohol and other drug service involvement; extent of involvement was variable, consisting of one-off contacts and/or episodic contact.

The type of services provided across the cases included residential detoxification programs and community office-based and outreach programs.

The significance of the alcohol and other drug issues identified did not always correlate with the intensity of the alcohol and other drug service provided. For example, a mother's alcohol and heroin use resulted in multiple episodes of alcohol and other drug service involvement; however, a father's alcohol problems did not result in the involvement of any services.

Family violence services

Of the 25 cases known to have had involvement with adult services, nine had the involvement of family violence services. Of those cases the focus of the family violence services was on supporting the women and not addressing the behaviour of the men.

The services provided included counselling and access to women's refuge services. Service engagement with women's refuges appeared to be predominantly episodic encounters.

There was limited evidence that reflected the complex nature of the violence and the potentially negative consequences for the adults and children. The range of services available to support families who have experienced violence, (including consultation services, counselling services for women and children and men's behavioural change programs for the violent perpetrators) were not widely utilised.

The recipients of specialist adult services

Key message

Child and specialist adult services need to engage more assertively with men as parents and provide them with greater support and strategies for behavioural change.

The analysis found that the majority of users of specialist adult services were women. In the few cases where men received a service, their level of involvement appeared relatively minimal.

Figure 6.2 shows that women were the main recipients of the specialist adult services provided.

Figure 6.2 : Recipients of specialist adult services (N=25)



The experience of the women

A significant amount of responsibility was placed on the women to ensure children's safety, although the women who left violent partners had little ongoing assistance and support. Once they left the relationship, they were deemed as acting protectively. There was little recognition given to the consequences of the violence on women.

Women affected by severe violence struggled to care for the children and a few consequently threatened to harm the child and commit suicide. At times, the children were subsequently placed with the father who had been violent to the mother. Limited help was provided to keep the women safe and assist the men to cease their violent behaviour. A pattern of separation and reconciliation was common in these cases, adding to the unpredictable and chaotic family situation.

Many women who experienced childhood or adult trauma (including sexual abuse, violence, or traumatic loss) had difficulties with substance misuse and experienced a range of trauma-like symptoms, including anxiety and depression. In some instances, they had a diagnosis of post-traumatic stress disorder. Parental substance misuse appeared to be part of a long-term pattern of managing traumatic experiences, but being substance affected often led to further trauma, such as involvement with violent men or volatile relationships. In several cases, violence was more likely to occur when both adults were alcohol affected, which would then exacerbate the traumatic impact on women, who were more likely to suffer significant injury.

Finding	Implications for practice
The gendered nature of family violence where women were largely the victims was not consciously recognised by professionals in most of the cases.	Understanding the importance of men taking responsibility and being held accountable as reflected in recent legislation is crucial to good practice with families.

The experience of the men

Little recognition was given to the significance of men as parents. In most of the cases, the role of the men as fathers and the nature of their relationship with their children were not sufficiently explored by services. Information about the fathers was limited and generally there was little or no direct engagement with them, despite Child Protection's long-term involvement in some of the cases. For example, even though one father was actively involved with his children and willing to work with Child Protection, meaningful engagement did not occur. Concerns regarding another father's mental health, were never directly assessed.

However, on occasions a different service approach was demonstrated, such as a case where a young man's desire to do well for his baby led to an overly optimistic view of him despite a history of violence, drug use and psychosis. In another case there was a concerted attempt to include a father who lived interstate. This effort occurred in the latter stages of the case and attempted to redress previous lack of engagement with him, because of his importance in the child's life.

The co-existence of family violence, parental substance misuse and parental mental illness was found to complicate another father's access to services, even when there was a willingness to engage. For instance, a father's history of violence excluded him from receiving services and his substance misuse and mental illness led to disagreement between agencies about which one should respond. When services were approached, a holistic response was not provided.

Finding	Implications for practice
A disproportionately high focus was apparent on women as parents in the cases considered.	Attention needs to be given to men as parents and their behaviours, even if they are not living with the child/family.

Extended family and other carers

While providing many children with opportunities to remain connected to family and community, kinship care can also pose particular difficulties, especially when there have been past family relationship issues. Managing relationships with the child's biological parents can be fraught when children are placed with extended family. For example, a family member declined to care for a child because of fear of the father and another kinship carer required the placement be undisclosed. There was also evidence that children were placed with carers who also experienced their own difficulties, which included concerns regarding drug and alcohol use and mental health issues. The strain of caring for additional children as well as her own children overwhelmed another carer.

The siblings

It appeared that the more children in a family, the less likely it was that each individual child would be seen in his or her own developmental context; their needs tended to be considered as a group. The quality of sibling relationships was not often noted and opportunities for children to develop and maintain sibling bonds appeared variable.

Siblings were usually regarded as a source of comfort and connection, but the needs of other siblings could also inadvertently increase risk. For example, an infant was left in the care of his unstable father while the mother was responding to crises involving older siblings exhibiting high risk behaviour.

Involvement of other services

Key message

Collaboration, communication and clear referral pathways are important elements of effective practice between child and adult services.

The families' experiences were not limited to the involvement of specialist adult services, they also included universal services such as maternal and child health nurses, general practitioners, family support and

early childhood development and education. Specialist child-focused therapeutic and assessment services, Aboriginal and family preservation services and police services were also involved in some cases. Of these services, general practitioners and the police had significant roles with the families.

General practitioners provided primary care and support to parents with substance misuse and mental health issues and in several cases, the general practitioner was the only professional who had a long-term relationship with the parent.

Finding	Implications for practice
Parents appeared to be more willing to access universal services and maintain involvement with them.	Universal services, such as general practitioners and maternal and child health nurses have a pivotal role in working with highly vulnerable adults and their children, so need to be actively engaged by Child Protection.

Access to specialist adult services was identified as a significant issue in rural areas, due to the long distance between the service and the parent's home. Almost half of the cases were managed in rural areas.

Finding	Implications for practice
Responding to families with complex problems, collaboration between services and access to services were identified as issues in rural areas.	All services, individually and collectively, need to develop specific responses to these issues in the rural catchment areas.

The police had a primary role in family violence matters. Police roles included providing support to the victims of violence and assisting them with legal proceedings, removing the perpetrators from the family home and transporting women and children to a safe house.

All six of the Aboriginal children and their families were involved to some extent with Aboriginal organisations or workers. The roles of the Aboriginal services included

direct service provision to the family, advocacy and providing advice to other services.

Child Protection interaction with specialist adult services

Within Child Protection one of the most commonly understood ways of working to facilitate effective collaboration and information sharing is to hold timely case conferences. It is not mandatory to hold case conferences for all children reported to Child Protection, however the Child Protection Practice Manual states that a case conference is recognised as a critical mechanism for obtaining and sharing case information, the coordination of necessary professional involvement, and critical decision making (DHS, 2012).

There are also statutory requirements to hold best interests planning meetings involving the family and the relevant workers, to undertake planning for children (CYFA 2005 4.3, S166–171 Case Planning and Stability Planning). Practice requirements about convening meetings for children in a range of circumstances are also detailed in the Child Protection Practice Manual.

The analysis found little evidence of effective communication and collaborative practice between Child Protection and other specialist adult services. Contact with these services generally occurred at times when case information was sought and referral for specialist assessment, treatment or support was required by Child Protection. The Victorian Child Death Review Committee (VCDRC) *Annual report of inquiries into the deaths of children known to child protection 2011* also found that collaborative practice would have been assisted through the greater use of case conferencing (OCSC, 2011).

The purpose of Child Protection's contact with the specialist adult-focused services was not always clear. There appeared to be minimal communication between services and this was particularly evident in the cases where the parents had been hospitalised. There was limited evidence of discussions regarding their progress, hospital discharge and capacity to care for children upon return to the family home. This lack of communication added to the unpredictability of the child's situation, as the family did not know if the parent was returning home.

The analysis also found a tendency to making a direct referral, rather than consultation, although there was evidence that referral alone did not guarantee that family members would engage with services. A more flexible and targeted use of consultation may have assisted in dealing with the frustrations when a referral was deemed inappropriate by specialist services. In such complex cases as these, there was a need for all services involved to take a holistic approach. This meant that in the first instance it was necessary to have a shared understanding of how each of the risk factors may relate to each other and impact on the child.

Key message

Effective treatment programs for adults need to incorporate their clients' roles as parents, particularly in terms of preventing further harm to their children.

An approach that uses more specialist consultation rather than direct involvement with services may be better suited to such complexity and allow for better reflection on how to deal with the underlying problems. This is an issue recognised by Brandon et al (2005) who concluded from their analysis of 20 cases that 'Professionals from agencies who contribute less routinely to the process of safeguarding children should be consulted as experts and be empowered to play a fuller part ... Consultation could be used prior to or in place of referral.'

Consultation is important, regardless of whether or not a specific service was actively involved, or was likely to accept a referral, as enlisting the knowledge of others with different expertise is beneficial. However, there appeared to be a general lack of understanding of how specialist adult services could effectively assist in contributing to positive outcomes for children.

Finding	Implications for practice
There was minimal assessment of the impact of the three parental risk factors on children demonstrated across all cases.	Engagement with specialist services to gain a fuller understanding of the impact of the parental risk factors is needed.

7. A framework for a multi-service system response

Key message

An approach of ‘no wrong door’ by family violence, drugs and alcohol and mental health services should increase service accessibility for vulnerable parents and their children.

The National Framework advocates for a national action priority of ‘joined up service delivery’. This has been a significant step toward establishing a comprehensive and integrated multi-service system response to the wellbeing and protection of vulnerable children and their families. This priority to ‘join up service delivery’ has been a driving factor for many of the reforms that have occurred across Child Protection, family violence, alcohol and other drug and mental health services.

Key message

Improved collaboration is required within and between child and specialist adult services.

Families presenting with the identified risk issues present significant challenges for Child Protection and specialist adult services. A comprehensive and balanced understanding of multiple parental risk factors is required by both child and specialist adult services.

The Victorian Government Directions Paper (2012) recognises that while people’s lives are complex and multi-faceted, government services are often single issue and siloed and the traditional approach of single-issue cohort-specific services does not meet the needs of vulnerable children.

Key message

Barriers to effective service provision need to be reduced and resolved within and across all levels of child and adult services for positive outcomes to be achieved.

The combination of multiple parental risk factors creates a dynamic that requires a concerted and concentrated effort by child and specialist adult services ‘... to look

beyond their individual specialisms and to think more broadly to acknowledge the impact of parental behaviour on children ...’ (Brandon et al., 2005; Cleaver et al., 1999; Brandon et al., 2008). For this to occur, a robust leadership approach is required to support and facilitate the necessary changes across all levels of each service system.

Figure 7.1: Framework for effective collaboration between services.

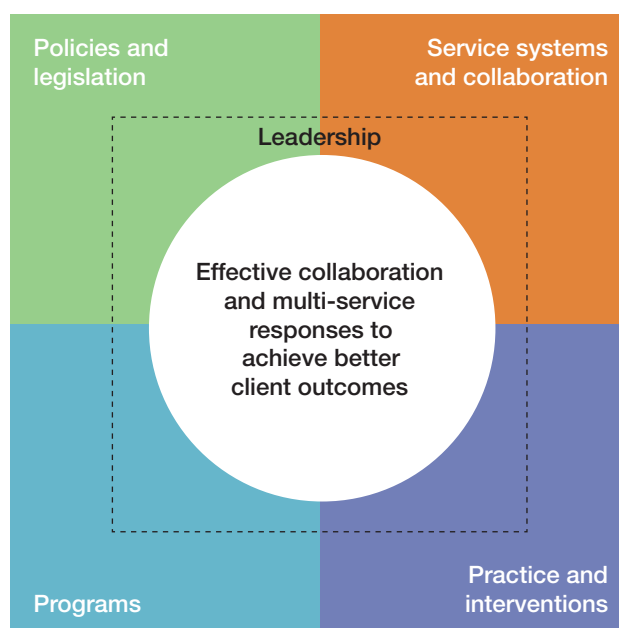


Figure 7.1 presents a framework to guide the changes that are required across the service system.

At the centre of the framework is leadership, key to facilitating change across all four components of the framework. If effective and sustainable change is to occur, each component needs to be addressed. Change requires the coming together of a number of components which need to move together in concert (Bolman & Deal, 2003). For example, for an Aboriginal child, specific policies and programs apply in addition to those they share with all children. Regardless of whether or not the program itself is Aboriginal or mainstream, the practice and approaches to collaboration need to be culturally informed and sensitive.

a) Leadership strategies

Key message

Leadership at all levels by senior managers in organisations is pivotal to support the process of effective collaboration between all services.

Leadership is required at all levels if organisational culture is to change and a new regime of effective collaboration between sectors is to work effectively for vulnerable children and their families. The reforms underway with *One DHS organisational review* and those proposed in the Directions Paper aim to build effective and connected services and provide leadership at the whole of government level to achieve 'joined up' and strategic action.

The move from single independent service sectors to 'intensive cooperation' (Humphreys, 2007), or a multi-system response requires a major change in thinking within and across the service sectors. For collaboration to be valued in practice at the grass roots level, it needs to be modelled and structurally supported at all levels through leadership, irrespective of type. It is however important that those who hold positions of power in each sector support collaboration.

A variation of the model of 'distributed leadership' could be useful (Timperley, 2005), as this approach recognises the leadership roles in each of the fields, instead of assuming one service automatically takes the lead in every aspect of the case. For example, case management and the associated coordinator roles involve leadership, but so does the provision of specialist consultation and advice.

b) Policy and legislation strategies

All four service sectors have policies which address cross-sectoral collaborative practice. The importance of all service sectors working together is in keeping with research findings that provide a growing evidence base that when working with families, carers and children, better outcomes are achieved for all clients when a holistic response is provided.

Despite existing protocol arrangements with Child Protection and specialist adult services, effective collaboration did not routinely occur in the cases considered. Barriers to effective collaboration need to be addressed at the policy level, as well as at the program and practice level. Constraints to collaboration identified in this project include:

- different legislative requirements
- different government departments
- different systems and structures
- insufficient knowledge across the systems
- information sharing barriers
- different professional terminology 'language'
- complex systems needed to manage demand for services and finite resources.

Policy can be a proactive force in leading the implementation of change, overcoming barriers that may exist in organisational culture and practice and identifying program development options.

Legislation has been enacted in the areas of Child Protection (2005), Family Violence (2008) and is in progress regarding Mental Health (draft exposure bill 2010) and this context is supportive of service integration and holistic approaches to vulnerable families.

c) Service systems and collaboration strategies

Child and specialist adult services need to further develop strategies to improve collaboration across all levels of the service system, including strategies that support or resource their workforce adequately for collaboration.

This is essential for good practice with families who experience multiple issues, despite different requirements in legislation, policies, programs and practices and differences in organisational culture and language across the sectors. When providing funding for the delivery of a specific service, this should also allow for linkages between services to occur. Consideration needs to be given to the space in the service system within

which collaboration takes place, as often this is not always 'owned' by any one service system. Even when services such as Child Protection have requirements for collaboration, there is no guarantee that this will actually occur between services.

Services can employ a range of strategies to strengthen or improve collaboration. Some of these strategies to improve and support effective collaboration may include: establishing new structures and processes; adapting existing structures and processes; and developing time-limited processes at central and local levels that require and enable collaboration and may lead to new initiatives. Knowledge building and workforce development are two such initiatives that provide opportunities for purposeful collaboration between professionals across Child Protection services and specialist adult services.

Knowledge building strategies

There is opportunity for professionals to develop further knowledge across Child Protection and adult specialist services. Knowledge sharing between professionals in the different service systems enables them to remain open to new and different ideas. Consistent with a pluralist approach to assessment and intervention, this ensures that more than one possibility for understanding issues and exploring solutions are recognised.

Shared knowledge potentially provides professionals with the opportunity to learn what is necessary in order for them to meet their own clients' needs in these other areas. This is consistent with Scott's (2009) call for mutual capacity building and broadening the focus of each field.

Professionals with specialist knowledge potentially have a valuable role in providing advice and consultation to their counterparts, within and across other service systems. The ability to solicit and effectively use the expertise of other professionals is an essential skill and a practice that was absent in many of the cases subject to the analysis.

Training and development strategies

The benefits of ongoing training and development for professionals to enhance knowledge, skills and practice are well recognised by Child Protection and specialist

adult services. Through training and development there is opportunity for all professionals to build on existing knowledge and share knowledge with colleagues across the different service sectors.

The value of joint training between the different service sectors that also specifically focuses on the parenting and developmental needs of children and young people and how services can identify the impact of the three issues on parental functioning cannot be underestimated.

As Tandon and colleagues (2005) suggested; any worker visiting a family at home should be trained in how to address risks of family violence, mental health issues and drug and alcohol usage. Strategies that promote knowledge building and sharing across Child Protection and specialist adult services could include joint training initiatives and professional forums addressing the impact of multiple risk factors on parenting, worker exchange programs and worker orientation and induction programs.

d) Program strategies

The increasing scale and complexity of families presenting with multiple risk factors has implications for program development across all four service sectors. Of the cases considered, there were few families who simultaneously received services from all four service sectors in a coordinated way; instead the families' engagement with different services appeared to be more *ad hoc*.

Although there was evidence of various services' involvement from across the four sectors, there was no evidence that the services provided were designed to explore all the identified issues of family violence, parental substance misuse, parental mental illness and the impact of these issues on parenting and the child. When working with families with complex and multiple needs, services need to work together to deliver an integrated multi-service system response. Greater capacity building across all four sectors is needed to recognise, engage and effectively respond to the needs of both children and adults. O'Connor's (2002) report on mental health services and Child Protection, suggested the following program initiatives:

- embedding adult-service workers in child-focused services
- embedding child-focused workers in adult-services
- creating portfolios in each service pertaining to the other
- coordinating assessments between adult-focused and child-focused services.

e) Practice and intervention strategies

As recently highlighted by the VCDRC, ‘the essence of thinking and acting collaboratively is for all practitioners to consider themselves part of a team beyond their own service and beyond their own disciplinary training ...’ (VCDRC, 2011). The exchange of information between Child Protection and specialist adult services provides opportunities for developing greater insight into the family’s level of function and dysfunction and becoming more sensitive to adult and child related issues. Meaningful connection between services can be promoted through relevant case discussions that address all relevant risk factors and the impact of these risk factors on the adult’s capacity to function adequately as a parent, in order to ameliorate the risk of harm to the child.

Irrespective of purpose, (whether for information and advice or assessment purposes), the exchange of information between services needs to be appropriately focused and relevant to the risk factors identified for the child. For example, ‘...the symptoms of the mental illness and their subsequent impact on parenting, the parent/child relationship or the home environment, are more important in explaining impacts on children than the diagnostic label applied to the parent’s mental health problem’ (Smith, 2004).

When multiple risk factors of family violence, parental substance misuse and parental mental illness co-exist, developing an understanding of their complexities both individually and collectively is an integral part of the assessment process. The extent of information required for assessing child/adult safety and wellbeing, at times, can overwhelm professionals across Child Protection and adult specialist services. Developing practice strategies to assist professionals in managing the volume and complexity of information in cases that present with multiple risk factors is therefore required.

8. Conclusion

The group analysis has shown that when families experience multiple issues, Child Protection and specialist adult services are likely to intersect. Specialist adult services all have an important role to play in the protection, safety and wellbeing of children. Family violence services, alcohol and other drug services and mental health services can help reduce the risk of child abuse and neglect through improved and effective collaboration across all levels of service delivery.

The practice of working collaboratively needs to be valued, supported and adequately resourced by all services. Collaboration needs to be modelled and structurally supported by senior staff and managers in the Child Protection, family violence, alcohol and other drug and mental health service sectors. Linkages between services are more likely to occur when appropriate resources are made available to support the workforce in working collaboratively.

This analysis has demonstrated that a concerted effort needs to be made by all child and specialist adult services to systematically address the constraints that impede the successful development of a multi-service system response to vulnerable children and their families. The move from single independent services to a more joined up approach requires a major change in thinking across all levels of service provision to ensure the goal of achieving better outcomes for vulnerable children and families is realised.

Effective collaboration needs to underpin work with highly vulnerable families and children. While this message is not new, the challenge remains about implementing what has been learned and embedding it into day to day practice to benefit vulnerable children and their families.

Glossary of terms

accident	Category of death; includes drowning, fire, road and rail trauma, falls and poisoning.
acquired/congenital illness	Category of death; includes prematurity, malignancy, seizures and infection.
adolescent	For the purposes of this report refers to children aged 13–17 years.
child abuse	Any action or lack of action that significantly harms a child's physical, psychological or emotional health and development.
Child Protection	The Victorian Child Protection program is delivered by the Department of Human Services (DHS) and is specifically targeted to those children and young people at risk of harm, or where families are unable or unwilling to protect them.
child-centred, child-focused	In this approach a child's best interests are the focus of services.
ChildFIRST	Child and Family Information, Referral and Support Team. A community-based centralised intake and assessment service and the single entry point for accessing the integrated child and family service sector.
closure	The last phase of Child Protection practice after a decision has been made to close a case.
cumulative harm	The existence of compounded experiences of multiple episodes of abuse or 'layers' of neglect that may be historical, or ongoing, with the strong possibility of the risk factors being multiple, inter-related and co-existing over critical developmental periods.
custody to Secretary order	This order gives sole custody of the child to DHS (the Secretary being the chief executive officer of the Department) but does not affect the guardianship of the child.
drug/substance related death	Category of death; includes drug overdose and deaths related to inhalant abuse.
family violence	Harmful behaviour that occurs when someone threatens or controls a family member through fear. It can include physical harm, sexual assault, emotional and economic abuse. This definition recognises the impact of violence on a child's development and safety.
foster care	A home-based care model that provides placements for children and young people who are unable to live with their families.
group analysis	Child death inquiry report that focuses on a group of individual child deaths.
guardianship to Secretary order	This order grants custody and guardianship of a child to DHS (the Secretary being the chief executive officer of the Department) to the exclusion of all others.
infant	For the purposes of this report refers to children aged 0-3 years.
intake	The first phase of Child Protection practice that involves receiving reports - concerning an unborn child, significant concern for a child's wellbeing or a child in need of protection – assessing the reported concerns and determining if the reported concerns meet the requirements of a protective intervention report.
interim accommodation order	This order is often made the first time a case comes before the Family Division of the Children's Court and covers the period of the adjournment and states where the child should live until the case comes back to court.

intervention order	intervention order is made by a magistrate. It has conditions to stop a person behaving in a way that makes another person feel unsafe.
investigation	The phase of Child Protection practice that involves direct and comprehensive investigation of the reported concerns and determines whether the circumstances of the child meet the legislative requirements of the <i>Children, Youth and Families Act 2005</i> that the child is in need of protection.
kinship care	Care within the family or friendship network of the young person or child. Kinship care may be informal or formally approved by Child Protection.
mental illness	A medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.
neglect	Includes failure to provide the child with an adequate standard of nutrition, medical care, clothing, shelter or supervision to the extent where the health or development of the child is significantly impaired or placed at risk. A child is neglected if they are abandoned or left uncared for over unreasonable periods of time.
non-accidental death	Category of death; includes death due to physical abuse, assault and homicide.
notification	Report made to Child Protection of concern that a child is at risk of abuse or neglect. This term has been replaced with the term 'report' as per section 28 of the <i>Children, Youth and Families Act 2005</i> .
out-of-home care	Placement of children and young people who are subject to subject to a statutory order with individuals and services approved or licensed under the <i>Children, Youth and Families Act 2005</i> . Out-of-home care includes home-based and residential care services provided and monitored by community-based organisations.
pre-school age	For the purposes of this report refers to children aged 4–5 years.
protection order	The phase of Child Protection practice that involves ongoing assessment of harm, and the safety, stability and development of a child during the course of a protection order.
protective intervention	The phase of Child Protection practice that involves ongoing intervention after an allegation of child abuse or neglect is substantiated.
report	Consistent with the <i>Children, Youth and Families Act 2005</i> , 'a person may make a report to the Secretary if the person has a significant concern for the wellbeing of a child'. This term replaced the term
residential care services	Provide temporary, short term or long term accommodation and care to children and young people who are unable to be placed in home-based care.
SIDS	Category of death; sudden infant death syndrome; requires autopsy and coronial authentication.
substance misuse	A maladaptive pattern of use or abuse of a range of substances, such as alcohol, illicit drugs and prescribed drugs.
suicide/self-harm	Category of death; includes deaths due to suicide and high risk-taking behaviour.
universal service	A service available to all families and which provides the critical foundations for health and learning for all children.

Abbreviations

CMHPSC	Community Mental Health Planning and Service Coordination
DHS	Department of Human Services
DoH	Department of Health
FAHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
IAO	Interim accommodation order
OCSC	Office of the Child Safety Commissioner
SIDS	Sudden infant death syndrome
VCDRC	Victorian Child Death Review Committee

References

- Baker, J., Miles, D., & Thorpe, R. (2006). *Parents with Complicated Lives: Do child protection services help or hinder?* CROCCS conference: Working together for families, Mackay, 4–6 August.
- Bolman and Deal (2003) *Reframing Organizations: Artistry, Choice, and Leadership*. Wiley.
- Brandon, M. Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., & Black, J. (2008). *Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What can we Learn? A Bi-ennial analysis of serious case reviews. 2003–2005*. University of East Anglia.
- Brandon, M. Belderson, P., Bailey, S. *Building on the Learning from Serious Case Reviews: a two year analysis of child protection database notifications 2007–2009*. Department of Education.
- Brandon, Dodsworth, & Rumball (2005). 'Serious case reviews: learning to use expertise', *Child Abuse Review*, 14, 160–176.
- Bromfield, L. *Families with Multiple and Complex Problems and Child Protection Services; Key Issues for Practice*, ACWA Conference, Sydney, (August 2010).
- Cleaver, H, Unell, I, Aldgate, J (1999) *Children's needs – parenting capacity: The impact of parental mental illness, problem alcohol and drug use and domestic violence on children*, London.
- Commonwealth of Australia (2009). *Protection Children is Everyone's Business: National Framework for Protecting Australia's Children 2009–2020: An Initiative of the Council of Australian Governments*, Canberra.
- Dale, P. & Fellows, R. (1999). 'Independent child protection assessments; Incorporating a therapeutic focus from an integrated context', *Child Abuse Review*, 8, 4–14.
- Department of Health (2011). *Families and Mental Health; A Parenting Resource Kit*.
- Department of Human Services (DHS). (2008). *Because Mental Health Matters: A New Focus for Mental Health and Wellbeing in Victoria: Consultation Paper*, May, DHS, Melbourne.
- DHS (2007). *The Best Interests Framework for Vulnerable Children and Youth*.
- DHS (2012). *Child Protection Practice Manual*.
- DHS (2007). *Cumulative harm: a conceptual overview*.
- DHS (2007). *Families where a Parent has a Mental Illness: a service development strategy*.
- DHS (2012). *Human Services: the case for change*.
- DHS (2011). *One DHS organisational review*.
- DHS (2005). *Parenting Support Toolkit for Alcohol and Other Drug Workers: Book One: Exploring Parenting*.
- DHS (2004). *Towards Collaboration: A Resource Guide for Child Protection and Family Violence Services*.
- Duncan, S. & Reder, P. (2003). 'How do mental health problems affect parenting?' In P. Reder, S. Duncan & C. Lucey (Eds), *Studies in the Assessment of Parenting*. (pp.195-210). Brunner-Routledge, New York.
- Government of Victoria, Directions Paper (2012), *Victoria's Vulnerable Children; Our shared responsibility*
- Humphreys, C. (2007). 'Domestic violence and child protection: Challenging directions for practice'. *Australian Domestic and Family Violence Clearinghouse*, Issues Paper 13.
- Lewin, L. & Abdrbo, A. (2009). 'Mothers with self-reported Axis I diagnoses and child protection', *Archives of Psychiatric Nursing*, 23(3), 200–209.
- Lord Laming (2009). *The Protection of Children in England: A progress report*.
- Mason, C., Subedi, S., & Davis, R.B. (2007). 'Clients with mental illness and their children: Implications for clinical practice'. *Issues in Mental Health Nursing*, 28, 1105–1123.
- Morrison, T. (1996). 'Partnership and collaboration: Rhetoric and reality'. *Child Abuse & Neglect*, 20(2), 127–140.
- New South Wales, Department of Community Services, (2005). *Assessment of Parenting Capacity*.
- O'Connor, R. (2002). *Child Maltreatment and Parental Mental Health Problems: An Investigation into the Mental Health Issues of Parents of Children on Statutory Orders – Final Report*, Bendigo Health Care Group, Bendigo.
- Potito, C., Day, A., Carson, E., & O'Leary, P. (2009). 'Domestic violence and child protection: Partnerships and collaboration'. *Australian Social Work*, 62(3), 369–387.
- Rupert, A. and Mayberry, D. (2007). 'Families Affected by Parental Mental Illness: A Multi-perspective Account of Issues and Interventions'. *American Journal of Orthopsychiatry* Vol 77, No.3, p362–369.
- Scott, D. (2009). 'Think child, think family: How adult specialist services can support children at risk of abuse and neglect', *Family Matters*, 81, 37–42.
- Smith, M. (2004). 'Parental mental health: Disruptions to parenting and outcomes for children'. *Child and Family Social Work*, 9, 3–11.
- Tandon, S.D., Parillo, K.M., Jenkins, C., & Duggan, A.K. (2005). 'Formative evaluation of home visitors' role in addressing poor mental health, domestic violence, and substance abuse among low-income pregnant and parenting women', *Maternal and Child Health Journal*, 9(3), 273–283.
- Timperley, H.S. (2005). 'Distributed leadership: Developing theory from practice', *Journal of Curriculum Studies*, 37(4), 395–420.
- Veysey, B.M., Andersen, R., Lewis, L., Mueller, M., & Stenius, V.M.K. (2004). Integration of alcohol and other drug, trauma and mental health services: An experiment in rural services integration in Franklin County, MA, *Alcoholism Treatment Quarterly*, 22(3), 19-39.
- Victorian Child Death Review Committee (2011) *Annual report of inquiries into the deaths of children known to child protection 2011*. Office of the Child Safety Commissioner.
- Victorian Government. *Children, Youth and Families Act 2005*
- Victorian Government. *Child Wellbeing and Safety Act 2005*
- Victorian Government. *Family Violence Protection Act 2008*
- Victoria Police Crime Statistics. 2011
- Victoria Police. *The Code of Conduct for the Investigation of Family Violence*.

Appendix 1: The potential impacts on the child of the three parental risk factors

Miscarriages/still birth	Hyperactivity. Inattention, impulsivity
Neurobiological impacts on developing brain in utero	Thought suppression
Born prematurely	Intrusive thoughts
Born with low birth weight	Exaggerated startle response
Born with developmental / neurobiological problems	Hypervigilance
Born drug-dependent, including potentially life threatening withdrawal symptoms (Neonatal Abstinence Syndrome)	Avoidant behaviour
Born with Foetal Alcohol Spectrum Disorders including permanent central nervous system damage especially to the brain	Withdrawn/ detached behaviours
Born with medical problems, such as immune deficiency, pneumonia, infections, breathing problems and transmitted health problems of mother such as Hepatitis B or HIV	Shame
Increased risk of death in early infancy due to low birth-weight and/or medical problems	Decreased empathy
Increased risk of Sudden Infant Death Syndrome	Repetitive or disorganised play
Increased risk of death from abuse/neglect (either as a causal/contributory factor)	Substance abuse by child/young person
Physical injury, due to accidents, assault, etc	Depression and other mood disorders
Neurobiological impacts on the developing brain	Posttraumatic stress disorder
Psychosomatic symptoms (e.g. headaches, gastric problems)	Fear of parent's death
Other physical ill health	Other anxiety problems or disorders
Insecure or disorganised attachment (or attachment problems unspecified)	Suicidal thoughts
Irritability, poor physical regulation	Poor academic performance
Affect/emotional dysregulation	Poor self-image and low self-esteem
Developmental delay	Impaired information processing
Developmental regression	Impaired problem solving
Language delay or difficulties	Aggression
Some cognitive delay or difficulties	Absconding
Problems with memory	Increased behavioural problems
Malnourishment	Holding burden of responsibility beyond developmental capacity
Sleep disturbance	Sexualised behaviours to others
	Problems with peer and other social relationships

Appendix 2: Key messages from research

- When there is more than one parent-based risk factor present, the likelihood of risk and the consequences of harm for the child can increase exponentially.
- Family violence, parental substance misuse and parental mental illness are associated with issues of poverty, homelessness, unemployment and isolation, which add to the difficulties experienced by the child.
- Continued attention needs to be given to individual and shared policy development across each of the sectors regarding collaboration about the role of parenting and assuming responsibility for children's wellbeing and safety.
- Professionals in all fields need to be supported in managing risk factors associated with family violence, parental substance misuse and parental mental illness to prevent oversimplification of issues and becoming overwhelmed by the complexity of the cases.
- When multiple parental risk factors co-exist, the assessment process needs to consider the complexity of each risk factor from an historical perspective and understand how they interrelate.
- Episodic and volatile patterns of behaviour can occur in parents experiencing the three identified risk factors and the cumulative impact of this unpredictable environment on children must be considered in assessment and planning processes.
- Family violence, parental substance misuse and parental mental illness are risk factors that can compromise a parent's cognitive processes and ability to make sound decisions for their child and respond to them appropriately in a crisis situation.
- Children exposed to family violence experience significant trauma and are at high risk of suffering physical harm and psychological and emotional trauma.
- A mother who is a victim of family violence may experience impaired cognitive and emotional functioning. This can increase the risk of child abuse and requires comprehensive assessment and targeted intervention.
- Addressing the impacts of the violence on women and children and providing parenting support can significantly contribute to children's wellbeing and safety.
- The impact of parental substance misuse on children will vary depending on the type and combination of substances, the pattern of usage and the age and vulnerability of the child.
- The impact of parental substance misuse on children's health and development is significant and can range from experiencing or witnessing high levels of violence to abuse and neglectful parenting.
- The impact of parental mental illness on children will vary depending on the type and severity of the mental illness, its chronicity and the age and vulnerability of the child.
- When a parent has been diagnosed with a mental illness, the risk of harm to the child is associated with the parent's behaviour and not their diagnosis.
- Child, family and specialist adult services together need to discuss the three parental risk factors and assess the impact of these on parenting and the child.
- Child and specialist adult services need to engage more assertively with men as parents and provide them with greater support and strategies for behavioural change.
- Collaboration, communication and clear referral pathways are important elements of effective practice between child and adult services.
- Effective treatment programs for adults need to incorporate their clients' roles as parents, particularly in terms of preventing further harm to their children.
- An approach of 'no wrong door' by family violence, drugs and alcohol and mental health services should increase service accessibility for vulnerable parents and their children.
- Improved collaboration is required within and between child and specialist adult services.
- Barriers to effective service provision need to be reduced and resolved within and across all levels of child and adult services for positive outcomes to be achieved.
- Leadership at all levels by senior managers in organisations is pivotal to support the process of effective collaboration between all services.

Appendix 3: Findings and their implications for practice

	Findings	Implications for practice
1	The combined presence of family violence, parental substance misuse and parental mental illness had a 'snow-ball' effect on the lives of children and families that exceeded the separate effects of each risk factor.	Risk factors cannot be considered in isolation from one another. The sum is greater than the parts and it is the impact of the whole which has to be considered in assessment and intervention.
2	Multiple risk factors appeared to be minimised by both families and professionals.	Underestimating the impact of parental risk factors is not acting in the child's best interests.
3	The majority of the children came from families with repeated risk factors.	Intergenerational issues of practices resulting in poor parenting can reduce the availability of extended family members who can appropriately care for children.
4	A tendency to divide people's difficulties into symptoms that required a separate response was evident in these cases.	Purposeful communication between services, timely case conferences, effective planning and case management are essential in cases where multiple services are involved.
5	The combinations of drugs and alcohol used by parents often did not appear to be adequately explored, nor was advice sought from this sector about the potential for impaired parenting capacity and the impact on children.	There is value in seeking consultation and learning from the expertise of drug and alcohol treatment services as part of effective collaboration.
6	The impact of a parent's formal diagnosis with a mental illness on their functioning and on the children's experience in the family was often not well understood by Child Protection.	The exchange of information between Child Protection and specialist adult services needs to be clear and directed at understanding the protective issues for the child.
7	All families had different levels of risk associated with poverty and many had concerns regarding transience, housing and unemployment.	The impact of poverty on the parents and the child and the significance of these additional stressors on family functioning need to be understood by professionals.
8	The majority of the children came from complex, changing family structures, where it was not always clear to professionals whether the father was living with the family and/or the nature of the sibling relationships.	Assessment needs to incorporate different aspects of family structures and functioning and recognise the dynamic structures and membership in many of these families.
9	The cases did not demonstrate meaningful engagement with individual family members by all service providers.	To conduct a holistic family assessment, workers need to engage and assess all family members and conduct age-appropriate assessments of the children.
10	In all the cases considered, parental risk factors impacted on the quality of children's lives.	The combination of risk factors should be given specific attention, not only in terms of cumulative harm, but also exponential risk.
11	Intensity of service involvement with vulnerable parents was low for parents of infants across all service types.	Engagement of all relevant service sectors is essential for effective early intervention strategies.
12	The presence of the three parental risk factors was associated with multiple types of maltreatment.	It is important to carefully consider the impact of these conditions on parental behaviour.
13	Children were rarely engaged directly, asked for information, or their opinions sought on their experience in the family.	The importance of working directly with children has been highlighted in relevant research and needs to be more widely implemented.
14	If a child grows up in an environment characterised by family violence, parental substance misuse and parental mental illness, there is an increased risk of the child developing similar issues in their adult life.	All services have a significant role in working towards achieving positive outcomes for the next generation of vulnerable children.

	Findings	Implications for practice
15	The cumulative effects of the three parental risk factors on children went beyond immediate safety issues and impacted on the child across all developmental stages.	Timely intervention is required to deal with the cumulative effects of the three parental risk factors on children and their differential impacts.
16	Child Protection practice required quality information gathering, meaningful analysis of information, carefully targeted interventions and an ongoing process of critical reflection, in order to be effective.	These are critical processes essential for everyday practice and coordination between services involved in partnerships of care directed at supporting vulnerable children and families.
17	Both child and adult services required an inclusive child-parent focus.	A paradigm shift is required so that both child and adult sectors take a child and family focus and adopt a 'think child, think family' approach.
18	Most of the children had more than one parent figure with one (or more) of the identified parental risk factors present.	When this occurs, the child has less likelihood of having a parent who is able to ensure their safety and development.
19	The gendered nature of family violence where women were largely the victims was not consciously recognised by professionals in most of the cases.	Understanding the importance of men taking responsibility and being held accountable as reflected in recent legislation is crucial to good practice with families.
20	A disproportionately high focus on women as parents was apparent in the cases considered.	Attention needs to be given to men as parents and their behaviours, even if they are not living with the child/family.
21	Parents appeared to be more willing to access universal services and maintain involvement with them.	Universal services, such as general practitioners and maternal and child health nurses have a pivotal role in working with highly vulnerable adults and their children, so need to be actively engaged by Child Protection.
22	Responding to families with complex problems, collaboration between services and access to services were identified as issues in rural areas.	All services, individually and collectively, need to develop specific responses to these issues in the rural catchment areas.
23	There was minimal assessment of the impact of the three parental risk factors on children demonstrated across all cases.	Engagement with specialist services to gain a fuller understanding of the impact of the parental risk factors is needed.

