Insights for social workers supporting families with complex needs

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Aboriginal and Torres Strait Islander peoples should be aware that this resource may contain images or names of people who have passed away.

There is growing recognition of the links between knowledge translation, policy and practice, particularly in the family and domestic violence (FDV) field (Cameron, 2020). Bridging the gap between research and practice is critical for the future of social and human service work (Cabassa, 2017). Practitioner knowledge provides an essential context for successful knowledge translation.

This literature review has informed the practice paper, Child-focused practice competencies: Structural approaches to complex problems. It covers core competencies for child-focused practice across five distinct yet overlapping areas:

- Working with the effects of intergenerational disadvantage on children and parents
- Child-focused social work practices with parents and children affected by substance use
- Child-focused social work practices with parents and children affected by mental illness
- Child-focused social work practices with children who have experienced trauma
- Developing a plan for children and families affected by violence.

This review begins with an acknowledgement of the interplay between the detrimental impacts of intergenerational disadvantage, substance use, mental illness, and trauma on parents and children, and the lived experience of family and domestic violence (FDV). From these varying impacts, we seek to extract implications and skills for practice. In this way practitioners can begin to reflect on how children's (and parent's) experiences of fear may be responded to in all service settings.

Who is this resource for?

This literature review has been developed to support child focused and structural approaches to social work. However, the literature is applicable to all professionals working with children and families facing disadvantage and adversity.

The importance of an intersectional lens

Intersectionality is about understanding how structures such as gender, race, disability, stigma and homophobia/transphobia work together to disempower certain groups of people while empowering others (Crenshaw, 2017). An intersectional lens can allow for a more holistic understanding of an individual child and their position in societal hierarchies.

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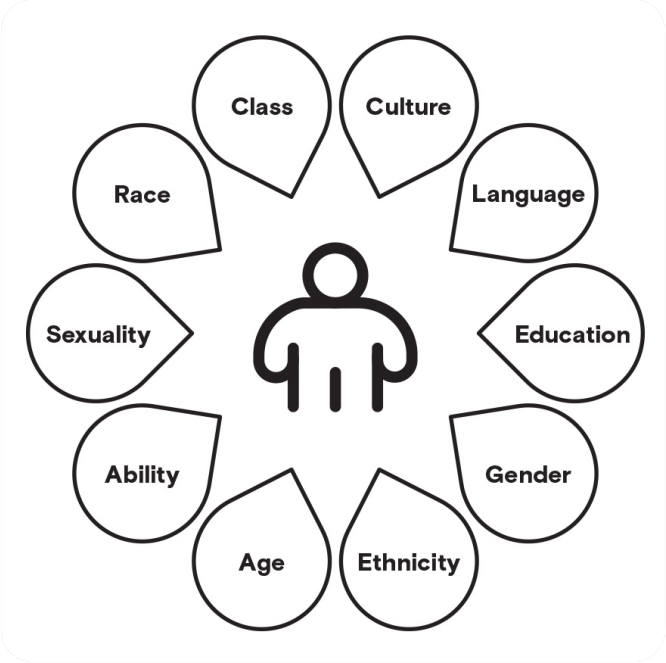
Intersectionality seeks to account for the complexities of life, especially with regards to more privileged and more oppressed identity groups. An intersectional approach calls attention to the fact that issues such as FDV are complex social problems that both reflect and are shaped by their societal and sociocultural context.



An intersectional approach is critical in understanding and preventing violence against women and children. Patriarchal power structures intersect with other systems of power (Our Watch & Women with Disabilities Victoria, 2022). Violence against women and children occurs in the context of both gender inequality and multiple other forms of structural and systemic inequality, oppression and discrimination. All of these intersect to influence the perpetration of violence; the prevalence, nature and dynamics of violence; and women and children's experiences of violence. Understanding and addressing these intersections is necessary to effectively target the drivers of violence against women and children and to work towards preventing this violence (Our Watch, & Women with Disabilities Victoria, 2022).

Child-focused practices and intergenerational disadvantage

Intergenerational disadvantage and its impact on children and parents

Intergenerational disadvantage can be defined as socioeconomic disadvantage which reflects people's lack of economic resources, social exclusion, and limited aspirations and political voice (Cobb-Clark, 2019). Disadvantage can persist within communities and across generations when there is a lack of socioeconomic opportunities for vulnerable people and their families.

The effects of intergenerational disadvantage on children and parents are well-documented. Education, socioeconomic background, family size and structure, ethnicity, cultural background, and language spoken at home may all contribute to intergenerational disadvantage (d' Addio, 2007). For some Australians, disadvantage is entrenched. Around 3% of Australians experience persistent and recurrent poverty, and some groups have a higher risk of entrenched disadvantage (Parliament of Australia, 2019a). Disadvantages experienced by younger generations cannot be attributed simply to their personal or their parenting experience but rather to unequal opportunities over the life course. Children's foundational advantages or disadvantages are based on the family and postcode they are born into (The Australian Centre for Social Innovation [TACSI], 2022). While some children have access to educational and other opportunities, others are born into generations of financial strain and reliance on government services.

Poverty, trauma, abuse and neglect, and mental health difficulties play out within and across generations, yet are often responded to as short-term, individual and isolated challenges (TACSI, 2022). Key pathways through which disadvantage is passed from Australian parents to their children include parental disability, chronic illness, and single parenthood (Cobb-Clark, Dahmann, Salamanca, & Zhu, 2017), in the context of long-term unemployment and low levels of education (Parliament of Australia, 2019b). Living in public housing and being dependent on income support can also entrench disadvantage.

Social determinants of health, largely responsible for health inequities, are shaped by the inequitable distribution of money, power and resources (Victorian Department of Health, 2018). These determinants can include:

- socioeconomic status
- education
- housing
- transportation
- food security
- psychosocial risk factors
- the social environment
- social support networks
- community and civic engagement
- social and civic trust; and
- the physical environment.

Individuals who experience persistent disadvantage tend to experience higher rates of ill-health.

Intergenerational disadvantage coexists with other forms of disadvantage and is associated with FDV (Kowalenko, Dolman, Palfrey, & Moss, 2018). Individuals who experience disadvantage may feel trapped by their circumstances or have difficulty imagining alternate futures for themselves and their families (Kowalenko et al., 2018). Intergenerational strengths, capacity and contribution, rather than simply disadvantage, should be considered when working with these families.

It is important to note that the very concept of intergenerational disadvantage is contested, with a range of competing explanations, justifications and narratives of poverty and disadvantage. It is not a term commonly used by children or families; rather it is one that has been developed by practitioners and researchers to describe the increasing prevalence of inherited childhood disadvantage that grows over time in marginalised families.

At its best, the concept of intergenerational disadvantage stimulates a political and systemic response to the widening social inequality that affects the care and protection of so many Australian children (Cobb-Clark et al., 2017). On the other hand, the concept can position children and their families as 'complex' and outside of the scope of reasonable prevention or early intervention services (Moss & Dolman, 2018). In this way, the concept has been challenged because it can overlook the strategies and strengths that families use to overcome adversity.

Intergenerational trauma in Aboriginal and Torres Strait Islander communities

The historical and contemporary impacts of intergenerational disadvantage and trauma on the health and wellbeing of Aboriginal and Torres Strait Islander families is a significant issue. Disadvantage among Aboriginal and Torres Strait Islander families can be seen across the domains of housing, education, health and employment. This includes the effects of intergenerational trauma related to colonisation, marginalisation, and policies of forced child removal and adoption (Australian Association of Social Workers [AASW], 2015), in addition to other discriminatory government policies (Hunter et al., 2020; Menzies, 2019).

Intergenerational trauma represents a form of historical trauma transmitted across generations (Healing Foundation, 2013) – from the survivors who directly experienced traumatic events, to the second and future generations (Atkinson, Nelson, & Atkinson, 2010). Intergenerational trauma can be defined as 'the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes' (Atkinson et al., 2010, p. 138). Addressing the social and economic disadvantages of Aboriginal and Torres Strait Islander peoples thus requires both appropriate acknowledgement of the trauma they have experienced, and systemic responses (AASW, 2015). Aboriginal and Torres Strait Islander families require healing strategies that are appropriate and sensitive to their needs, experiences and circumstances.

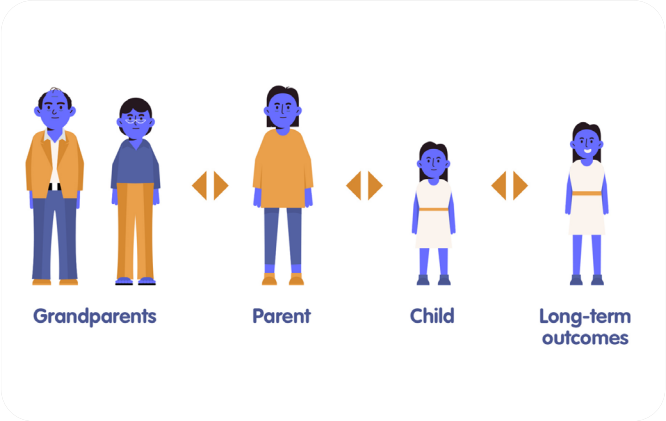
Practice messages: Supporting children and parents experiencing intergenerational disadvantage

Practitioners have indicated they want frameworks or 'roadmaps' to help them achieve positive outcomes for the mental health and wellbeing of children experiencing multilayered disadvantage (Cobb-Clark et al., 2017). The co-existence of FDV and intergenerational disadvantage is a practice challenge that is being considered by practitioners, researchers and organisations, with the view to creating innovative and safe solutions to complex problems (Moss & Dolman, 2018).

In their work with parents and children, practitioners often focus only on the individuals, symptoms and problems they are immediately presented with. This can mean that children of adult clients can remain invisible. It can also make it difficult to understand the full context or experiences of either the child or the parent. An intergenerational lens applies a broader focus, enabling prevention and early intervention with parents or children experiencing disadvantage (Emerging Minds, 2020a).

This approach supports parents to consider how their own challenges or experiences of adversity may interrupt their relationships with their children, and what they can do to be the best parent possible.

It helps parents to explore the aspects of their parenting that they value and which positively contribute to their children's social and emotional wellbeing. It also invites children to think about their relationship with their parents, and to ensure that their experiences, preferences and know-how are at the centre of their engagement with professionals (Emerging Minds, 2020a).



Child-focused practices with parents affected by substance use

The impacts of parental substance use on children

Parental substance use has significant and persistent negative effects on children across all domains of development, often into adulthood (Waddell et al., 2014). Substance use can affect familial functioning, parenting, and relationships (Lewis, Holmes, Watkins, & Mathers, 2014; National Center on Substance Abuse and Child Welfare [NCSACW], n.d.; Velleman, 2004).

Children of parents who use substances often experience emotional and mental health difficulties including depression, anxiety disorders, obsessive-compulsive disorder and attachment-related issues (Velleman & Templeton, 2016). Children may also experience difficulties relating to relationships, trust and the impacts of stigma (Hill & Mrug, 2015; Houmøller, Bernays, Wilson, & Rhodes, 2011; Templeton, 2009). They may develop difficult behaviours (Harwin, Madge, & Heath, 2010), underachieve academically (Torvik, Rognmo, Ask, Røysamb, & Tambs, 2011), use alcohol and other drugs themselves (Harwin et al., 2010; Houmøller et al., 2011), and become sexually active prematurely (Harwin et al., 2010; Kelley et al., 2010; Velleman & Templeton, 2016).

Substance use can also directly affect children by causing:

- trouble with bonding and attachment, due to the (using) parent's reduced emotional availability (Roche et al., 2014)
- increased exposure to verbal abuse, inappropriate behaviour and unsupervised or unsafe situations (Laslett et al., 2015)
- increased stress and chaos in the family home, putting strain on the parent-child relationship and resulting in behavioural, cognitive or emotional problems for the child (Moore, Noble-Carr, & McArthur, 2010)
- disruptions to family routines, leading to decreases in school attendance and academic achievement (Moore et al., 2010).

Children may also be forced to take on a parenting role for their parents and siblings (National Society for the Prevention of Cruelty to Children, 2019).

Children who are unable to live with their parents due to parental substance use issues may end up being cared for by other family members, including grandparents, or within private fostering arrangements (Nottinghamshire and Nottingham City Safeguarding Children Boards, 2004). Emotional support from extended family members, teachers and other adults can be pivotal in supporting children to thrive in this context (Waddell et al., 2014).

It is common for adults using substances to present to services with multiple, often competing, concerns – a level of complexity which many service systems struggle to address. This reflects the absence of services that are equipped to understand and respond to the risks associated with the co-occurrence of parental substance use and other issues, including mental health difficulties, poverty, financial difficulties and homelessness, amid child protection concerns (Isobe, Healey, & Humphreys, 2020; Moss, 2019). The same principles of assessment – that is, seeking to involve and partner with parents and, where appropriate, their children – should apply to practice with parents regardless of whether they use substances (Nottinghamshire and Nottingham City Safeguarding Children Boards, 2004).

Practice messages: A child-focused approach to supporting parents who use substances

While these are all potential risk factors for children whose parents use substances, it is also important to recognise that these factors are not always a given. Many parents have developed strategies to minimise risk, including planning for their children to be supported by other family members when they engage in substance use (Roche et al., 2014).

Where alcohol and other drug services adopt the sole focus of abstenance or harm minimisation with the adult client, they may risk missing the contextual factors that often surround substance use (Emerging Minds, 2017). Additionally, children may remain invisible in conversations with adult clients, where

contextual questions about their lives are not a part of regular assessments.

Trust and communication between adult- and child-focused services are essential to ensure children are best supported (Kroll, 2004). Where adults present to alcohol and other drug services, it is important that practitioners regularly ask about any children the client has, and how their substance use might be affecting their relationships with their family. Pilot programs with AOD workers have shown that building conversation guides into assessment tools can increase practitioners' confidence in asking about the domains of a child's life, even when the child is not present (Emerging Minds, 2020b).

Where children are present in services, seeing, hearing and engaging with them is essential to child-focused practice (Kroll, 2004). Professionals must ensure that they communicate openly with children and centre their perspective. This involves efforts to truly gain a sense of the child's life, for example, by encouraging them to tell their story in a safe space. Skills in observation and communication with children are key (Kroll, 2004). Further work is required to encourage and train professionals to work in ways that are more child-focused and integrated, ensuring that children's needs are considered within their broader context (Velleman & Templeton, 2016).

Family-focused practice is recommended as an approach to intervention (Lagdon et al., 2021). This practice style emphasises the family as a whole – rather than any one individual – as the focus for attention. Social work as a profession has historically recognised the importance of considering individuals in the context of their environment – including the family (Lander, Howsare, & Byrne, 2013). Applying a family-focused approach to parental substance use would require conversations with each family member, in order to understand its varying impacts (NCSACW, n.d.).

It is also important for professionals to assess the impact of parental substance use on children's health, education and social lives. Lander et al. (2013) emphasise the importance of treating the individual/s with substance use issues in the context of their family, arguing that failure to do so both ignores the impacts on the family and their own need for support, and overlooks their potential role in enabling meaningful change.

Social workers may assist by adopting trauma-informed, attachment-informed, and systems-based approaches to direct practice with individuals and families (Lander et al., 2013). This may be most effective when provided in the home (rather than the office). Particular attention must be paid to the impacts of intergenerational disadvantage and trauma.

Child-focused practices with parents affected by mental illness

The impact of parental mental illness on children

The lack of national data in Australia presents a major barrier to effective practice with parents with mental illness. Based on the limited data available, however, it is estimated that between 21–23% of Australian children are living, or have lived, in a household with at least one parent with a mental illness (Goodyear et al., 2015; Maybery, 2009). In Victoria alone, estimates indicate that 23.3% of all children have a parent with mental illness, and 20.4% of mental health service consumers are parents with dependent children (Boursnell, 2012; Maybery, 2009). Worldwide, 1 in 4 children currently live with a parent with mental illness (Maybery et al., 2019).

Parental mental illness can have substantial and lifelong impacts for individuals, families, societies and governments (Christiansen et al., 2019). Having a parent with a mental illness can create considerable risks and vulnerabilities for children's mental health and wellbeing (Afzelius, Plantin, & Östman, 2016; Goodyear, Cuff, Maybery, & Reupert, 2014). These children are likely to have higher rates of trauma than other children (Özcan, Boyacioğlu, Enginkaya, Bilgin, & Tomruk, 2016) and to experience emotional and/or behavioural difficulties (Isobel, McCloughen, Goodyear, & Foster, 2021). They are also more likely to be removed from the family home and taken into care (Leschied, Chiodo, Whitehead, & Hurley, 2005), and to develop their own mental health difficulties and/or substance use issues (Leschied et al., 2005; Mowbray & Oyserman, 2003).

A retrospective study conducted by Goodyear et al. (2014), however, highlighted the strengths developed by young adults living with parent/s with mental illness, including resourcefulness, confidence and maturity. Adults who experienced unsafe or inconsistent parenting as a child often express a desire to 'break the cycle' of adversity for their own children (Gibson, Lee, & Moss, 2021). Despite this, parents with mental illness remain largely stigmatised due to their illness (Boursnell, 2012). Parents accessing government mental health services often only do so during a crisis and remain fearful regarding their mental illness and its impacts on their family (Boursnell, 2012).

Mental health systems in Australia often fail to provide services specific to the needs of parents with mental illness (Boursnell, 2012; Nicholson & Biebel, 2002; Tabak et al., 2016). Historically, there has been a lack of awareness of the presence of children within the lives of parents with mental illness, and this is reflected in the tendency for adult and child services to work in isolation from each other (Bassett, 1999; Boursnell, 2012; Maybery, 2006). Responses to parents with mental illness may thus be initiated only when child protection concerns are raised, often once child abuse or neglect has already been identified (Boursnell, 2012).

Practice messages: A child-focused approach to supporting parents with mental illness

All practitioners play a key role in supporting children, parents and families to function cohesively where there is adversity. Practitioners who can sensitively and respectfully ask parents how their mental illness might affect their parenting and their children's social and emotional wellbeing, are critical in the provision of early identification and prevention responses to support children's mental health (Emerging Minds, 2020a).

Without support, mental illness can dominate an adult's identity, causing a strong sense of hopelessness and shame about perceived parenting failures. This sense of failure can continue a dominant negative narrative that most often begins in childhood, particularly in parents affected by intergenerational disadvantage and mental illness (Salveron, Schuurman, Kowalenko, & Moss, 2019, June).

The ability to enquire about aspects of the parent's knowledge, skills or values as an alternative to this dominant failure story is often a necessary entry point for successful engagement. This may involve an examination of the socio-political contexts of their adversity and the obstacles they have had to face. If a practitioner uses an intergenerational lens, they may become immediately interested in looking back to the parent's own childhood experiences (Gibson, Lee, & Moss, 2021).

Adopting family-focused and child-centric approaches when working with adults experiencing mental illness is key. Working solely with the parent as an individual (Goodyear et al., 2015) fails to recognise their continuing parenting roles and responsibilities (Reupert, Maybery, & Kowalenko, 2012), as well as their own concerns about their children's needs. Proactively responding to parenting and child-related concerns can avoid a crisis if a parent goes on to experience psychosis, severe mood or anxiety disorders and/or suicidal thoughts.

Family-focused approaches centre the family by both focusing on their strengths and assets and responding to clients within the context of their family and broader social environment (Hunter, 2014). Within family-focused approaches, the needs of children are highlighted in order to ensure that attention is paid to their safety and wellbeing, recognising that attending to these can improve treatment outcomes for parents (Hunter, 2014). Such approaches are well-suited to working with parents with mental illness as they are based on open communication, respect, and prioritising the needs and preferences of each family member.

Research indicates that mental health workers working with parents with a mental illness may feel that they lack the requisite skills to work with children (Reupert & Maybery, 2012). Combined with training and organisational barriers, this can prevent the implementation of family-focused interventions and approaches (Reupert & Maybery, 2012).

There is a general consensus that adult-focused services require a better understanding of the complex parental issues affecting children's safety and wellbeing (Hunter, 2014). The frequently individualistic view of issues like mental illness and substance use means that the broader relations and social contexts for individual problems are often overlooked, along with the interconnectedness of individuals and families (Hunter, 2014).

Child-focused practices with children who have experienced trauma

The impacts of trauma on children

Children can be exposed to trauma in numerous ways. A single acute traumatic incident may be considered a short-lived experience of trauma (Klain & White, 2013), with examples including natural disasters, accidents, or the loss of a loved one. Common responses to acutely traumatic events include helplessness and distress.

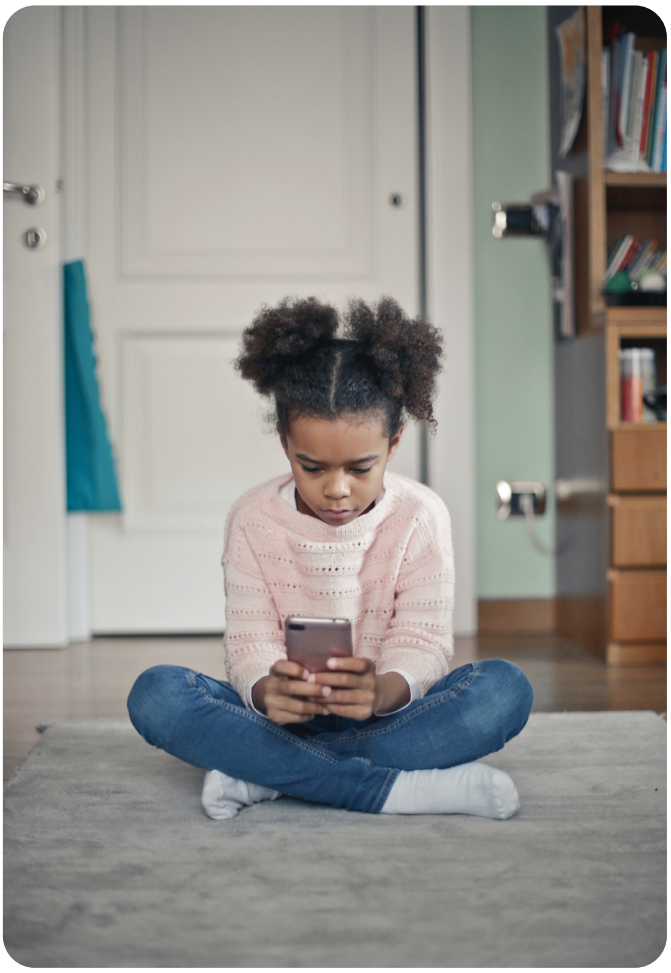
Children who experience chronic trauma, or prolonged exposure to traumatic situations such as FDV, physical or sexual abuse, medical trauma, and institutionalised oppression or war, may experience traumatic stress (Klain & White, 2013; Virginia Commonwealth University, 2020). This can lead to intense feelings of guilt, shame, distrust and fear for personal safety. The effects of chronic trauma are often cumulative, with each event serving to remind the child of prior trauma and reinforcing its negative impact (The National Child Traumatic Stress Network [NCTSN], 2013).

For some children, the effects of trauma are intergenerational (NCTSN, 2013). Historical, or intergenerational, trauma refers to continuing traumatic impacts, often extending over several generations, of an event or prolonged experience of trauma. Intergenerational trauma can come from experiences such as slavery, removal from homelands, dispossession, massacres and genocides, and cultural, racial or minority group oppression.

Children who have experienced trauma often have specific needs and requirements for care. Misdiagnosis and mistreatment of trauma and trauma-related symptoms is common (Virginia Commonwealth University, 2020).

Around 1 in 32 Australian children receive child protection services (Australian Institute of Health and Welfare, 2021a). A high percentage of children in the child protection system have a lived experience of trauma (Wall, Higgins, & Hunter, 2016), with many having long and complex trauma histories (Ko et al., 2008; Sullivan, Murray, & Ake, 2016). Statistics show children receiving child protection services have experienced emotional abuse (54%), neglect (22%), physical abuse (14%) and sexual abuse (9%) (Australian Institute of Health and Welfare, 2021b). Children in out-of-home care have a higher prevalence of mental health difficulties than the general population (Australian Institute of Health and Welfare, 2021c; Ko et al., 2008).

Children who experience trauma often face doubt, stigma and the possibility of experiencing further related trauma (Virginia Commonwealth University, 2020). The effects of trauma are both individual and complicated – many factors, including the availability of support services, contribute to the personal experience. Research indicates that people who have experienced trauma are more likely to develop severe mental health issues (including depression, anxiety and post-traumatic stress disorder), social and emotional problems, harmful coping mechanisms, and serious diseases (Virginia Commonwealth University, 2020).



Practice messages: A child-focused approach to working with trauma

The stories children have about their lives give meaning to their experiences (Collective Narrative Practices, 2015). When children endure traumatic

events without the language to make sense of their experiences, overwhelming narratives of self-blame and shame can develop. These stories, if left unchallenged, can dominate the stories children tell themselves throughout their lives. They can lead children to believe they're a 'loser' or a 'failure', which can in turn negatively affect their mental health, safety and ability to live a connected or meaningful life (Lippard & Nemeroff, 2015).

Helping children to consider the power differences between adults and children is often the first and most important step in counteracting shame and self-blame. There is important trauma-informed knowledge that can help children to take the first step in challenging the unhelpful meanings they've made from their experiences of trauma (Emerging Minds, 2022).

Understanding the trauma-informed approaches that can overcome unhelpful messages is central to quality care for children (Ko et al., 2008). Service staff who are knowledgeable about and sensitive to the effects of trauma are best positioned to work with children and their families, enhancing their capacity for resilience and recovery, and minimising the potential for re-traumatisation (Bunting et al., 2019). Ensuring that services are trauma-informed may also involve building cross-sectorial and collaborative inter-agency relationships, encouraging trauma-informed supervision, and ensuring that communication is consistent across organisations and sectors (Australian Institute of Health and Welfare, 2018a; Bunting et al., 2019; Loomis, Randall, & Lang, 2019).

Effective, trauma-informed services build trusting, collaborative relationships with children and the important adults in their lives (Bunting et al., 2019). This recognises that positive interpersonal relationships are significant resources for children and young people who have experienced trauma (Munisamy & Elze, 2020). Encouraging such connections and building networks of trusted adults can help children to feel more settled and assured.

Trauma-informed approaches require an understanding of the signs, impacts and options for addressing trauma (Virginia Commonwealth University, 2020). Effective screening for trauma, via assessment protocols at multiple levels (Ko et al., 2008) is one way in which the trauma-related needs of children can be identified. Early intervention programs can lead to better outcomes and contribute to optimal child development (Geiger, 2021). Trauma-informed care for children must be tailored to their age and developmental level and, for very young children, may require non-verbal approaches, including play therapy and art (Hodas, 2006). Older children may benefit from both verbal and non-verbal interventions including storytelling and role-playing (Hodas, 2006; Schwarz, & Perry, 1994). All children, though, need flexible and compassionate approaches across multiple sites, such as schools and community services (Hodas, 2006). Trauma-informed care must also respond to the specific and culturally relevant needs of the child, their family, and their community (Benjamin, 1996; Hodas, 2006).

Practice that is both child-focused and trauma-informed can improve outcomes for children and families (Klain, 2013). Trauma-informed care seeks to ensure that the provision of services and interventions do not inflict further trauma on a child or reactivate past traumatic experiences (Hodas, 2006). With the right support and care, children can begin to heal from past trauma and develop resilience (Hodas, 2006; Klain & White, 2013). Practitioners working with children in the context of trauma must, however, be properly supported in their organisations to minimise the potential for vicarious trauma, compassion fatigue, secondary trauma and burnout (Query, 2015).

The effects of trauma are pervasive. Identifying and responding to trauma as early as possible is important for improving the outcomes for children and young people (Hodas, 2006), and fostering trusting relationships and environments conducive to healing is crucial (Virginia Commonwealth University, 2020).

Trauma-informed care cannot be accomplished through a single technique or practice; rather, it requires constant evaluation, attention and sensitivity (Virginia Commonwealth University, 2020). A model of trauma-informed care aims to make connections between presenting symptoms and behaviours and the individual's trauma history, recognising that this understanding is necessary to promote healing and growth (Hodas, 2006). Thus, practitioners may seek

to understand the traumatic origins of 'problem' behaviours, reframing these as signs of strength and resilience. From a trauma-informed perspective, the complex, nuanced needs of individuals reflect their personal histories, vulnerabilities and triggers, and require tailored responses (Virginia Commonwealth University, 2020).

The impact of family and domestic violence on children in Australia

Family and domestic violence (FDV) can have lifelong impacts on children's development, mental health and wellbeing. It is important to adopt a child-focus when exploring the lived experience of FDV on children and families, as the voices of children are often marginalised or silenced in research, service provision and policy. Indeed, children living with FDV have historically been referred to as the silent, forgotten, unintended, invisible and/or secondary victims (Edleson, 1999; Kovacs & Tomison, 2003; Tomison, 2000). More recently, the impacts of children's exposure to FDV have been increasingly recognised and identified as a form of child abuse, both in Australia and internationally (Richards, 2011).

Although it is difficult to accurately determine the scope and impact of FDV on children, research and practice reveals many children experience violence. For example, more than two-thirds (68%) of mothers with children in their care when they experienced FDV reported that their children had seen or heard the violence (Australian Insitute of Health and Welfare, 2018b).

Language has shifted in recent years, with terms such as 'being exposed to violence', 'living with violence' and 'being affected by violence' replacing 'witnessing violence', to better describe the experiences of children living in violent homes (Powell, & Murray, 2008). Children may experience violence or abuse by seeing or hearing it, or may be more directly involved in violent incidents (Richards, 2011).

A climate of fear

As language has changed regarding children's experiences of FDV, so has our understanding of how children make meaning of their experiences. We now know more about the efforts that children make in making sense of the difficult and frightening situations that surround them (Lamb, Humphreys, & Hegarty, 2018). Where practitioners understand the implications for children who live in a climate of fear, they are more likely to provide vital prevention and early intervention work that will benefit children's safety and mental health (Wendt, 2018).

Whose job is it?

Many experiences of children who live in a climate of fear remain invisible. This is why it is critical that professionals working in non-specialist services have the appropriate skills to engage parents in initial conversations where FDV is a presenting issue (Emerging Minds, 2018). If responding to children experiencing violence is only seen as a specialist area, children's experiences may continue to remain invisible. But if generalist service providers can recognise when women and children are living in a climate of fear, and feel confident to respond accordingly, they are in a much better place to support the family's recovery (Hughes, 2018).

Developing a plan for children and families affected by violence

Centring children in the experience of family and domestic violence

Children's experiences and voices are underrepresented in academic and practice literature (Callaghan, Alexander, Sixsmith, & Fellin, 2018). However, there is broad recognition that witnessing and experiencing FDV has profound effects on children and young people (Rivett, Howarth, & Harold, 2006). Family violence services are more likely to focus on the needs of parents than the immediate needs of children (Stanley, Miller, Richardson Foster, & Thomson, 2010); therefore prevention and early intervention are important to reduce children and young people's exposure to violence and respond promptly when violence occurs (Osofsky, 2004).

Family violence occurs in all communities. It undermines both the individual's and the family's capacities to live full lives and contribute to their communities (Neave AO, Faulkner AO, & Nicholson, 2016). Responding to children and families affected by violence requires service systems to be adequately equipped with appropriate resources, knowledge and skills. Importantly, measures to support and build the capabilities and resilience of individuals, families and communities must exist alongside family violence prevention, early intervention and recovery services (Neave AO et al., 2016).

Practice messages: A child-focused approach to planning for families affected by violence

Planning for children and families affected by violence and abuse should be grounded in a holistic and systematic assessment of children's safety and needs (Victorian Government Department of Human Services, 2013). A holistic assessment evaluates a child's needs, their unique stage of development, their familial context and circumstances, their culture and identity, their risk and trauma response and their relationship to the perpetrator (Victorian Government Department of Human Services, 2013). Establishing a relationship of trust is critical for working with children and families in ways that will facilitate the development of meaningful plans (Wales, 2021).

Children have a right to be involved in decisions that affect them (appropriate to their developmental stage) and should therefore be given opportunities to contribute to their own assessments (Victorian Government Department of Human Services, 2013). Children should be assessed individually, in a way that respects and affirms their cultural, spiritual, gender and sexual identity. Assessments are an ongoing process, recognising the changing views, needs and risks of adults, children and young people. Children should be provided the time and space to communicate when they feel ready, in a way that suits them. They may require support to ensure that their voices are heard and taken seriously. Children's needs are best met by whole-of-system responses, involving universal, specialist and tertiary services as required (Victorian Government Department of Human Services, 2013).

Services responding to FDV must always be attentive to the risk presented by perpetrators. This includes monitoring changing circumstances and behaviours that might indicate a heightened risk of harm and lethality (Bragg, 2003). A family-sensitive and safety-oriented practice approach for responding to FDV is informed by the ongoing assessment of risk. It focuses on:

- the experiences and unique risks of the child and their circumstances
- the experiences of the victim parent and their circumstances; and
- the perpetrator's pattern of behaviour towards victims (adult or children) (Family Safety Victoria, 2021).

Note that the focus on victims' circumstances does not imply that victims (parents/children) are responsible for the perpetrators' violence. Instead, this recognises that victims' circumstances may impact on (increase or reduce) their immediate safety. The perpetrator's responsibility for his violence remains central.

Interagency, cross-sector and cross-discipline collaboration in FDV work is considered good practice (Family Safety Victoria, 2017). Collaborating with community partners and sharing appropriate information provides an integrated system response to children and their families (Bastian, 2022; Child and Youth Protection Services, 2020; Wendt, Bastian, & Jones, 2021).

The process of case planning and goal setting should be both strengths-based and realistic. Adopting a strengths-based approach in work with families can help parents to recognise the ways in which they are already acting to protect their children (Child and Youth Protection Services, 2020). A trauma-informed approach is also critical – ensuring that models of service and interventions are sensitive and responsive to the indicators and impacts of trauma (Campo, 2015). This includes the careful use of language when discussing violence and ensuring all communication is child-appropriate (Child and Youth Protection Services, 2020).

Further considerations

Working with Aboriginal and Torres Strait Islander families

Additional considerations are necessary when working with Aboriginal and Torres Strait Islander children and families to ensure that assessments and responses are culturally appropriate, respectful, and recognise the strengths and social, cultural and historical contexts of First Nations communities. This includes the recognition that Aboriginal and Torres Strait Islander children and families continue to be impacted by colonisation and the associated disconnection from kin, culture and Country; forced child removal policies and practices; and institutionalised abuse and neglect (Stanley, Tomison, & Pocock, 2003).

It is important to also acknowledge the strength and resilience of Aboriginal and Torres Strait Islander peoples in the form of kinship systems and connection to spiritual traditions, ancestry and Country, representing key protective factors in the face of adversity (Women's and Children's Health Network, n.d.). First Nations children are more likely than non-Indigenous children to be supported by extended family, reflecting the critical role of family and kinship in supporting children's social and emotional wellbeing. Working in partnership with local Aboriginal and Torres Strait Islander organisations is important for keeping children safe in their families and connected to culture and community (Child and Youth Protection Services, 2020). This can be achieved through early intervention and preventive strategies, whole-of-community activities and targeted programs (Neave et al., 2016).

Working with culturally and linguistically diverse families

Working effectively with culturally and linguistically diverse families also requires an approach that is culturally responsive and respectful. Cultural responsiveness can be fostered by:

- understanding cultural values in relation to children and child-rearing
- mobilising and drawing on the child's and family's narratives
- providing space for the child and family's perspectives to be heard
- using familiar language and cultural concepts
- listening to and validating children and families' experiences of racism, racist violence and cultural stereotyping; and
- seeking to address service or system barriers (Women's and Children's Health Network, n.d.).

Recognising the potential for cases of undiagnosed/untreated trauma among people from a refugee or migrant background is also critical (Child and Youth Protection Services, 2020).

Conclusion

This literature review has presented an overview of key messages for practice when working with children and families in situations of complexity. It has considered issues relating to intergenerational disadvantage, substance use, mental illness, and trauma, as well as planning to keep children safe in cases of FDV. The importance of trauma-informed and strengths-based practice that is informed by intersectionality and balances a child-centred and family-focused approach has been highlighted.

Practical strategies for professionals supporting families with complex needs can be found in our accompanying practice paper, Child-focused practice competencies: Structural approaches to complex problems.

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