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National Workforce Centre for Child Mental Health

Child-focused practice competencies: Structural approaches to complex problems

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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.

This paper is designed to help practitioners respond sensitively and respectfully to parents who are experiencing adversity, while maintaining a focus on the developmental, social and safety needs of children. It features practice advice from Professor Sarah Wendt and leading academics from Flinders University's Social Work Innovation Research Living Space (SWIRLS), who describe structural approaches to complex issues.

This resource focuses on five key issues affecting families in Australia: intergenerational disadvantage, parental substance use, parental mental illness, family and domestic violence (FDV), and trauma. It will help you to:

- consider how issues of intergenerational disadvantage, substance use, mental illness, trauma and violence can affect children's social and emotional wellbeing
- understand structural approaches to disadvantage that shift parents away from self-blame and create opportunities for a focus on children
- develop family stories of connection, resilience and strength that foster confidence and agency in the care for children; and
- bring children's developmental needs into focus, while resisting shaming parents.

Who is this resource for?

Throughout this paper you will hear social work academics reflect on their child-focused approaches and practices. While these videos speak directly to social workers, the key messages and learnings from this resource are applicable to all practitioners working with children, parents and families.

An intersectional and structural lens on disadvantage

Contemporary research and data provide practitioners with more information on the experiences of disadvantage than at any other time in history. However, there is work to be done in bridging the gap between research and practice in social and human service work (Cabassa, 2017).

There has been an increased understanding of the need to recognise the significant and specific enduring effects of family and domestic violence on children (Richards, 2011). Accordingly, previous terminology such as 'witnessing violence' has largely been replaced with language that better reflects the experiences of children living in violent homes (Powell & Murray, 2008), such as 'being exposed to violence', 'living with violence' and 'being affected by violence'.

This resource was co-produced with:

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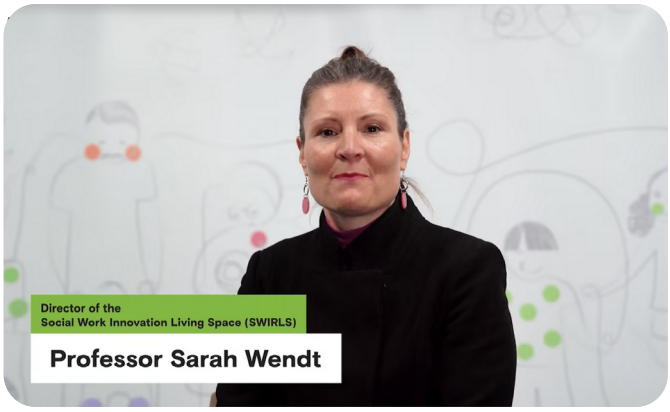
SWIRLS

The National Workforce Centre for Child Mental Health (NWC) is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program.

This recognises that children may experience violence by seeing or hearing it, or may be more directly involved in violent incidents (Richards, 2011).

Adopting an intersectional lens is critical for thinking about FDV and all societal issues. It ensures that we do not lose sight of the societal and sociocultural structures which impact on children and young people. This approach recognises that intersecting societal issues occur in the context of social divisions and hierarchies across multiple dimensions, drawing attention to both the complexity and diversity of experiences of violence, isolation and disadvantage (Our Watch & Women with Disabilities Victoria, 2022).



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Child-focused practices and intergenerational disadvantage

Intergenerational disadvantage is commonly defined as socioeconomic disadvantage which reflects not only people's lack of economic resources, but also their social exclusion and limitations on their aspirations and political voice (Cobb-Clark, 2019). Disadvantage can persist within communities across generations when there is a lack of socioeconomic opportunities for vulnerable people and their families.

Factors that may contribute to intergenerational disadvantage include:

- education
- socioeconomic background
- family size and culture
- ethnicity
- cultural background; and
- language spoken at home (d' Addio, 2007).

The effects of intergenerational disadvantage on children and parents are well-documented. However, intergenerational disadvantage is not a term commonly used by families. Rather it's 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 structural response to the widening social inequality that affects the care and protection of so many Australian children (Cobb-Clark, Dahmann, Salamanca, & Zhu, 2017). In contrast, the concept can position children and their families as 'complex' and outside of the scope of reasonable prevention or early intervention services. 'Where do I start with this family?' is a familiar question posed by practitioners when presented with the multiple co-existing issues faced by children and families experiencing disadvantage (Moss & Dolman, 2018).

For some Australians, disadvantage is entrenched. Around 3% of Australians experience persistent and recurrent poverty, and some groups have a higher risk of inherent disadvantage (Commonwealth of Australia, 2019). 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 (The Australian Centre for Social Innovation, 2022).

Key pathways through which disadvantage is passed from parents to their children include parental disability, chronic illness and single parenthood, in the context of long-term unemployment and low levels of education (Cobb-Clark et al., 2017; Commonwealth of Australia, 2019). Living in public housing and being dependent on income support can also cement disadvantage.

Social determinants of health, largely responsible for health inequities, are shaped by uneven distribution of money, power and resources (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 (Mental Health Professionals Network [MHPN], 2018). Individuals who experience disadvantage may feel trapped by their circumstances or have difficulty seeing alternate futures for themselves and their families (MHPN, 2018). Intergenerational strengths, capacities and contributions, rather than simply disadvantage, should also be considered when working with these families.

It is important to recognise that the intergenerational trauma and disadvantage faced by many Aboriginal and Torres Strait Islander peoples is rooted in colonisation and dispossession, marginalisation, racism and policies of forced child removal. While the effects have been devastating and continue to impact First Nations peoples today, there are also demonstrations of significant strengths and resilience that can be learned from more broadly (Emerging Minds, 2019).

Practice strategies for supporting children and families experiencing intergenerational disadvantage

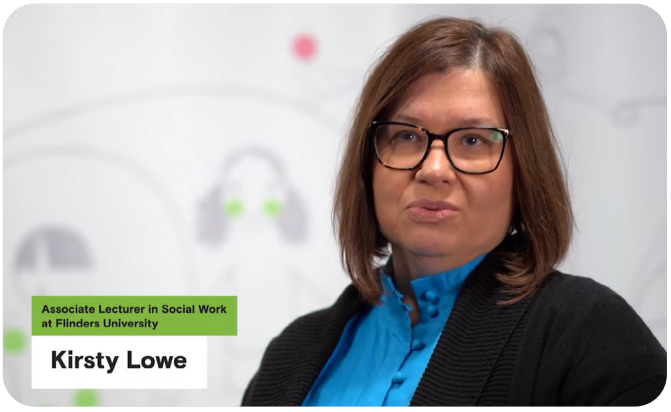
Intergenerational disadvantage is often characterised by very limited social capital (relationships, support networks and community connectedness). Parents with low social capital have very limited supports during times of stress or crisis. They often seek support from services or are in contact with statutory services (Price-Robertson, 2011).

Practitioner curiosity can become easily disqualified amidst the many adverse issues affecting parents. When multiple adversities are grouped together, these stories of hopelessness may overwhelm both the practitioner and the parent. Amidst this hopelessness, practitioners may stop listening for evidence of parenting hopes and strengths that reinforce children's safety (Moss & Dolman, 2018).

A structural approach to intergenerational disadvantage recognises that the parent is not responsible for their experiences of adversity; societal inequity is. It also helps practitioners to be curious about the strategies that parents have used in the past to overcome structural disadvantage.

This practitioner curiosity is possible even where parents are behaving in ways that make their children feel scared or insecure. Once stories of skills, strengths and know-how are available to parents they can be replicated, and a blueprint for safe and nurturing care can be developed. These stories can contain rich descriptions of how parents and children have overcome adversity, and practitioners can therefore become interested not only about intergenerational disadvantage, but intergenerational capacity and contribution. Parents can feel less trapped in their current circumstances and less limited in what might be possible for the care and wellbeing of their children. These conversations can challenge fatalistic perceptions of children's circumstances for both parents and practitioners (Moss & Dolman, 2018).

In the following video (6 minutes, 9 seconds), academics from SWIRLS speak about child-focused practice approaches to use with parents experiencing intergenerational disadvantage.



WATCH THE VIDEO TO LEARN MORE

Reflection questions

Take a moment to reflect on the following questions:

- How can practitioners discuss the challenges for parents experiencing disadvantage, while maintaining a focus on the mental health and wellbeing of children?
- What practice policies and assessment tools does your organisation use to support child-focused and parent-sensitive conversations with parents where multiple disadvantages exist?
- How do you help parents to describe their histories of resilience and connection, while also acknowledging the effects of adversities? How can this increase parenting confidence?

Child-focused practices with parents affected by alcohol or drug use

Recent research has confirmed what many practitioners have long understood: that parents who attend services often experience co-existing issues including substance use concerns, child protection involvement, mental health difficulties, poverty, family and domestic violence, and a history of trauma (Buchanan, 2018; Heward-Belle, 2017). Many of these parents have had their first children at a young age, without the social structures or relationships with their own parents to support nurturing relationships with their children (Early Intervention Research Directorate, 2019).

A structural approach to addressing issues with alcohol and other drug use holds two clear aims. Firstly, there are many co-existing reasons why parents use substances, and they need to be supported to recover through nuanced and non-stigmatising practice. Secondly, the safety and wellbeing of children living with parents experiencing substance use issues can be negatively impacted in the short and long term.

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).

It is common for children of parents who use substances to experience emotional and mental health issues including depression, anxiety disorders, obsessive compulsive disorder and attachment-related issues (Velleman & Templeton, 2018). Children may also experience difficulties with trust and forming relationships, and may struggle with 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 prematurely sexually active (Harwin et al., 2010; Kelley et al., 2010; Velleman & Templeton, 2018).

Children who are unable to live with their parents due to parental substance use issues may be cared for by other family members, including grandparents, or within private fostering arrangements (Nottinghamshire and Nottingham City Safeguarding Children Boards, 2009). 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).

Many adults using substances present to services with multiple, often competing concerns. A holistic understanding of support needs for children and parents is vital (Isobe, Healey & Humphreys, 2020; Moss, Crooke, Rollbusch & Lee, 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 or not they use substances (Nottinghamshire and Nottingham City Safeguarding Children Boards, 2009).

Practice strategies for working with parents who use alcohol or other drugs

Practitioners today are more understanding of the multiple reasons behind substance use. However, despite these understandings, the effects on children are no less real or dangerous. It is this balance between acknowledging the multiple traumas that many parents have or may continue to experience, while not minimising the effects of unsafe parenting on children, that remains one of the most challenging aspects of modern practice (Moss et al., 2019).

Every practitioner who works with parents engaged in substance use can explore and support trauma, stigma and shame without losing sight of the child's experience. This asks practitioners to use their knowledge of child-focused and trauma-informed practice to conduct sensitive, non-judgemental and hopeful conversations about parents' strengths and hopes for their children's future.

There continues to be few treatment options and limited evidence to inform intervention programs for children whose parents are affected by substance use (Lewis et al., 2014; Velleman, 2004). For this reason, it is important that the wellbeing needs of children are attended to in adult-focused service delivery.

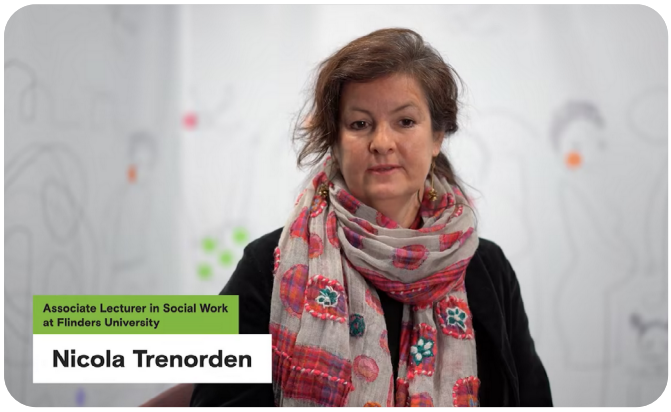
For this to occur, trust and communication between adult- and child-focused services are essential to ensure children are best supported (Kroll, 2004). It is also important that parents can tell their stories in ways that highlight the strategies they have used to keep their children safe, or to nurture wellbeing despite their substance use. While these stories are important in reducing stigma for parents, practitioners need to be clear about the non-negotiable safety needs of children. A strengths-based approach with parents should not involve a minimisation of those behaviours which are placing their child's safety or wellbeing at risk.

Family-focused practice attends to the family as a whole, rather than any one individual. Social work as a profession has historically recognised the importance of considering individuals in the context of their environment – including the family – and this approach emphasises that focus (Lander, Howsare &

Byrne, 2013). Parents regularly report their hopes that practitioners will ask about their children, because this is invariably a strong motivating factor in their desire to make a change (Moss, et al., 2019).

Applying a family-focused lens to parental substance use requires conversations with each family member, in order to understand the 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 the potential role of the family in enabling meaningful change.

In the following video (5 minutes, 43 seconds), academics from SWIRLS discuss child-focused practice approaches for working with parents experiencing substance use issues.



WATCH THE VIDEO TO LEARN MORE

Reflection questions

Take a moment to reflect on the following questions:

- How do you meet the challenge of creating safety and trust for parents to tell their stories, while maintaining a focus on the mental health of children?
- Are there questions you regularly ask parents about their children?
- How do you avoid making moral judgments about parents whose substance use affects their children's social and emotional wellbeing?

Child-focused practices with parents affected by mental illness

It is estimated that up to 1 in 5 young people live in families with a parent who has a mental illness (Reupert, Maybery & Kowalenko, 2013; Goodyear et al., 2015). Parental mental health difficulties can have substantial and lifelong impacts for individuals, families, societies and governments (Christiansen et al., 2019), and create considerable risks and vulnerabilities for the mental health and wellbeing of children in particular (Afzelius et al., 2016; Goodyear et al., 2014).

Children living with parental mental illness are more likely to experience trauma (Özcan, Boyacioğlu, Enginkaya, Bilgin & Tomruk, 2016), emotional and/or behavioural difficulties (Isobel, McCloughen, Goodyear & Foster, 2021); be removed from the family home and taken into care (Leschied, Chiodo, Whitehead & Hurley, 2005); and 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 that young people living with parent/s with mental illness also develop significant strengths including resourcefulness, confidence and maturity.

Without support, mental illness can dominate an adult's self-identity, causing a strong sense of hopelessness and shame about perceived parenting failures. This sense of failure can continue a dominant negative narrative that often begins in childhood, particularly in parents affected by intergenerational disadvantage and mental illness (Salveron, 2019; Gibson, Lee & Moss, 2021). Therefore, you may only realise a parent has a mental illness when child protection concerns are raised (Boursnell, 2012).

Family-focused approaches centre the family by both focusing on their strengths and assets and responding to children's needs within the context of their family and broader social environment (Hunter & Price-Robertson, 2014). Highlighting the needs of children ensures that attention is paid to their safety and wellbeing, while also recognising the ways this can, in turn, lead to improved treatment outcomes for parents. Family-focused approaches prioritise open, respectful and collaborative communication and are attentive to the individual needs and preferences of each family member. With a focus on building the family's strengths, practitioners seek to engage, empower and partner with families by connecting them with comprehensive, culturally relevant, community-based networks of supports and services (Child Welfare Information Gateway, n.d.).

Issues such as mental illness and substance use are often thought about in narrow, individualised terms. This means that broader societal contexts are often overlooked, as well as the interconnectedness of individuals and families (Hunter & Price-Robertson, 2014). Research indicates that mental health workers may feel ill-equipped to work with parents, most notably in their knowledge and understanding of children's needs (Reupert & Maybery, 2012). This, along with systemic and organisational issues, presents a major barrier to effective family-focused interventions and approaches.

Practice strategies for supporting parents with mental illness

Parents with mental illness often describe feeling anxious about meeting with practitioners. They may have had previous negative experiences, be afraid of being judged, or be concerned about child removal. Invariably, parents have found ways to manage their mental illness that provide opportunities to develop strong relationships with their children. This does not mean their mental illness does not affect their child's wellbeing. But taking the time to inquire about parenting histories, stories of success and strategies that work helps to position the parent as capable and caring, rather than a problem that needs to be fixed.

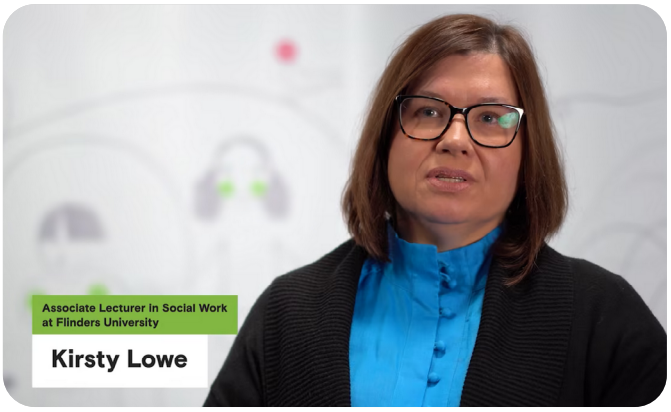
A problem-solving approach is commonly used to understand a client's behaviour, history, lifestyle, or presenting symptoms (Emerging Minds, 2021). But adopting a position of curiosity will ensure better outcomes for both you and the family. Taking a curious stance means asking questions about more than just symptoms. Instead, it involves considering the parent's knowledge and expertise and asking questions to develop a picture of the ways in which the parent's mental illness might be affecting their children (Emerging Minds, 2021).

Parents are more likely to talk to practitioners about parenting, their children and family when they believe practitioners are genuinely curious and want to connect with them on a human level. A curious stance also helps practitioners to avoid only focusing on their own goals. Instead, curiosity promotes a collaborative approach and encourages and supports a parent's autonomy.

Some parents may initially be reluctant to share concerns about their parenting or their children's responses or behaviours. Curiosity, combined with a trusting therapeutic relationship, will help you and the parent to develop a clearer understanding of what is going on for their child (Emerging Minds, 2021).

Working solely with the parent as an individual (Goodyear et al., 2015) fails to recognise their continuing parenting roles and responsibilities (Reupert & Maybery, 2012), as well as their own concerns about their children's needs. Adopting family-focused and child-centred approaches when working with adults experiencing mental illness is key to successful interventions. Working proactively can also help to avoid crises.

In the following video (5 minutes, 24 seconds), SWIRLS academics speak about child-focused approaches to working with parents with mental illness.



WATCH THE VIDEO TO LEARN MORE

Reflection questions

Take a moment to reflect on the following questions:

- How do you help parents who experience mental illness to describe both the adversities they are currently facing, and the ways they have responded successfully to adversities in the past?
- How do you help parents to examine their own stories of being parented?
- What questions might you ask to bring questions of hope and resilience to the fore?
- How would you begin to help parents plan for their children's safety and wellbeing, as they get clearer about their stories?

Child-focused practices with children who have experienced trauma

The detrimental effects of trauma on children, both in childhood and later as adults, have been widely acknowledged. Children can be exposed to trauma in numerous ways. A single acute traumatic incident – such as a natural disaster, accident, or the loss of a loved one – may be considered a one-off experience of trauma. Common responses to such incidents include feelings of helplessness and distress (Klain & White, 2013). Children who experience chronic trauma or prolonged exposure to traumatic situations, such as exposure to FDV, physical or sexual abuse, and institutionalised oppression may experience traumatic stress. Chronic trauma can evoke intense feelings of guilt, shame, distrust and fear for personal safety (Klain & White, 2013).

The effects of chronic trauma are often cumulative, with each event serving to remind the child of prior trauma and reinforcing its negative impact (National Child Traumatic Stress Network, 2013). The effects of trauma can also be intergenerational. Historical, or intergenerational, trauma refers to continuing traumatic impacts (often extending over several generations) of an event or prolonged experience of trauma (National Child Traumatic Stress Network, 2013). Intergenerational trauma can come from experiences associated with slavery, removal from homelands, dispossession, massacres and genocides, and cultural, racial or minority group oppression.

The effects of trauma are both personal and complicated. Many factors, including the availability of support services, contribute to an individual's unique experience of trauma. Children who experience a one-off traumatic incident will usually begin to recover over time, with the care and support of their loved ones and community. But research indicates that some children and young people, particularly those who have experienced chronic trauma, are at risk of post-traumatic stress, anxiety, depression and substance use issues, as well as difficulties with education, relationships, and so on (Australian Child & Adolescent Trauma, Loss & Grief Network, 2010).

Self-blame and shame are common in children who experience trauma and develop mental health disorders such as anxiety and depression (Australian Institute of Family Studies, 2014). Self-blame and secrecy can have long-lasting consequences for a child's mental health. Feelings of self-blame in particular can be exacerbated when a child has a pre-existing relationship with the perpetrator.

Complex trauma includes multiple adversities which can negatively affect children's development, wellbeing and self-worth, challenging their engagement with their family, school or peers (Hervatin, 2021). Research with adults who experienced trauma shows that children want and need supportive adults to help them tell their stories in safe and respectful ways (Guy, 2020; Moss & Klapdor, 2022). This is why it is so important for practitioners to be skilled in allowing children to tell their stories – so they do not live with the pervasive negative effects of self-blame and secrecy throughout their lifetimes.

Practice strategies to support children who have experienced trauma

Early identification is shown to be the most effective strategy to support children's recovery from trauma (Emerging Minds, 2020). Although there are many specialist skills involved in trauma practice, all practitioners can develop the skill to identify trauma.

Trauma-informed approaches emphasise the importance of 'trauma-specific knowledge and skills' that meet the specific needs of clients, while also recognising the potential for services to retraumatise clients through 'standard or unexamined policies and practices' (Center for Substance Abuse Treatment, 2014). Effective, trauma-informed services build trusting, collaborative relationships with children and the important adults in their lives (Bunting et al., 2019). These services recognise 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 settled and confident.

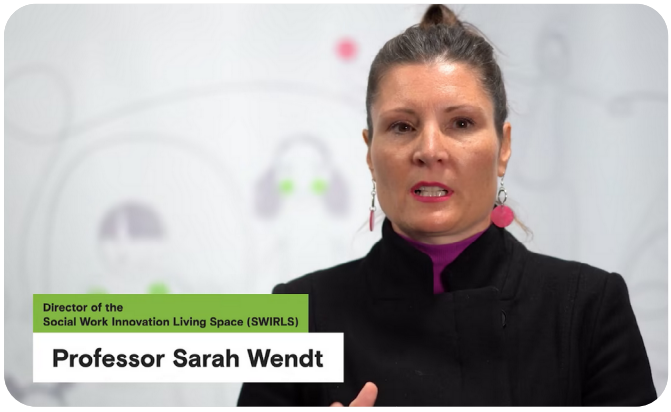
Early intervention programs can lead to better outcomes and contribute to optimal child

development (Geiger, 2021), and trauma-informed approaches to practice are central to quality care (Ko et al., 2008). With the right care and support, children can begin to develop resilience (Klain & White, 2013) and heal from past trauma (Hodas, 2006).

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 art and play therapy (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 community services and schools (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).

Evidence-based resources on trauma should be made available to providers and families, and efforts made to ensure continuity of care across the service system (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 (Australain Institute of Health and Welfare, 2018a; Loomis, Randall & Lang, 2019), encouraging trauma-informed supervision, and ensuring that communication is consistent across organisations and sectors (Bunting et al., 2019). 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).

In the following video (6 minutes, 44 seconds), SWIRLS academics discuss strategies for supporting children who have experienced trauma.



WATCH THE VIDEO TO LEARN MORE

Reflection questions

Take a moment to reflect on the following questions:

- How do you work with children to develop trust and safety, so that they can be supported to tell their stories?
- In the context of your work, how do you make decisions about what information to share with children? Which principles and frameworks support you in making these decisions?
- What activities or strategies do you use to help children feel more comfortable in their engagements with you? What do you notice about how children react to these activities or strategies?

Developing a plan for children and families affected by violence

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

Family and domestic violence occurs across society. It undermines the capacity of individuals and families to live full lives and contribute to their communities (Neave, Faulkner, & Nicholson, 2016). To effectively respond to children and families affected by violence, service systems need 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 et al., 2016).

A child-focused approach to family and domestic violence planning

Planning for children and families affected by violence 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
- unique stage of development
- familial context and circumstances
- culture and identity
- risk and trauma response; and
- 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 facilitate the development of meaningful plans (Law Society of New South Wales, 2021).

Children have a right to be involved in the decisions that affect them. They should therefore be given opportunities to contribute to their own assessments in ways that are both appropriate to their developmental capacity and that respect their cultural, spiritual, gender and sexual identity (Victorian Government Department of Human Services, 2013). Children should be provided the time and space to communicate when they feel ready, in a way that suits them; and 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). Interagency, cross-sector and cross-discipline collaboration in FDV work is particularly important for ensuring children and their families receive an integrated system response.

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

- the experiences and unique risks of the child and their circumstances
- the experiences of the parent and their circumstances; and
- the perpetrator's pattern of behaviour towards partners or children (State Government of Victoria, 2021).

Adopting a strengths-based approach to your work with families helps parents to recognise the ways in which they are already acting to protect their children. 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).

In the following video (7 minutes, 8 seconds), SWIRLS academics speak about developing a plan for children and families affected by violence.

WATCH THE VIDEO TO LEARN MORE

Reflection questions

Take a moment to reflect on the following questions:

- How do you engage a parent who is experiencing violence in conversations about their child's safety and wellbeing?
- How do you focus on the parent's own agency without making them feel responsible for the violence?
- How do you engage parents who perpetrate violence? How do you support them to understand the effects of the violence on their children? What questions do you ask?

Summary

This paper has presented an overview of key themes in the literature concerning working with children and families in situations of complexity including intergenerational disadvantage, substance use issues, mental illness, and trauma, as well as planning to keep children safe in situations of FDV. On this basis, it is evident that effective practice in situations of complexity is trauma-informed and strengths-based, viewed through a structural and intersectional lens, and balances a child-centred and family-focused approach.

Developing respectful and honest relationships with parents is key to this practice approach. Understanding the challenges parents have faced, the strategies they use to overcome these challenges, and their hopes for their children is critical. At the same time, an honest relationship allows for a genuine understanding of the effects of adult adversity on children. This understanding is key to the safety and wellbeing of children who are living with complex and intersecting issues such as disadvantage, parental substance use, mental illness, trauma and violence.

Important components of these practices include avoiding assumptions, considering the situation from the child's perspective, orienting parents toward the lens of the child, and striving to be 'in tune' with children. Having a critical awareness of the dominant discourses that influence our perceptions of children emerged as a strong theme, along with an emphasis on recognising that 'children are not the problem'.

Building rapport and connection with families helps them to develop an understanding their own values and priorities, as a critical basis for engaging in difficult conversations. Robust professional and reflective supervision is a space in which practitioners can reflect on and explore their own assumptions, to support them in these difficult conversations.

In summary, it is evident that there is considerable overlap between and across the five themes of intergenerational disadvantage, substance use, mental illness, trauma, and family and domestic violence. Staying child focused in an adult-centric world is challenging work, demanding a dogged determination to keep children's safety and wellbeing always in sight.

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The National Workforce Centre for Child Mental Health (NWC) is funded by the Australian Government Department of Health under the National Support for Child and Youth Mental Health Program.