Reconceptualising family violence intervention and prevention

Family Violence Death Review Committee

4TH AUSTRALASIAN CHILD DEATH INQUIRIES & REVIEW CONFERENCE
Ngā mate aituā o tātou
Ka tangihia e tātou i tēnei wā
Haere, haere, haere

The dead, the afflicted, both yours and ours
We lament for them at this time
Farewell, farewell, farewell
Cumulative patterns of harm

1st Generation: Conquered males were killed, imprisoned, enslaved or in some way deprived of the ability to provide for their families.

2nd Generation: Many men overused alcohol and/or drugs to cope with their resultant loss of cultural identity and diminished sense of self-worth. Government responses to emerging substance misuse problems have directly and indirectly led to the traumatisation of individuals who had not been previously affected, and the exacerbation of trauma in those already suffering the effects of trauma-related illnesses.

3rd Generation: The intergenerational effects of violence manifest in the increased prevalence of spousal abuse and other forms of domestic violence. The breakdown in the family unit that accompanied this violence ‘required’ caring governments of the day to remove ‘at risk’ children from their mothers and place them in the care of suitable, in many cases non-Indigenous, families.

4th Generation: Trauma begins to be re-enacted and directed at the spouse and the child; signifying a serious challenge to family unit and societal norms of accepted behaviour.

5th Generation: In this generation, the cycle of violence is repeated and compounded, as trauma begets violence, with trauma enacted through increasingly severe violence and increasing societal distress.


Complex lives amid trauma

- A traumagram maps an individual’s (and their family’s) experiences of trauma, such as child abuse and neglect, sexual abuse and intimate partner violence, across extended families (including siblings and step-parents), as well as current and previous relationships. They include known children of the various adults, alcohol and other drug use, protection orders, Child, Youth and Family (CYF) involvement, children in care and imprisonment associated with any particular family member.

- Traumagrams render visible patterns of violence, abuse and neglect across generations and in past and present relationships.
Understanding sensemaking

Relationship
Family
Community
Health services
Police
CYF
Women’s Refuge
Corrections
A ‘Systems’ Model for Family Violence Death Review

NATIONAL/GOVERNMENT DYNAMICS
Public policy, political context and priorities

LOCAL ORGANISATIONAL DYNAMICS
- Organisational culture and management of individual agencies
- Organisational culture and management of multi-agency system as a whole

FAMILY & INTERPERSONAL DYNAMICS
- Patterns in practitioners’ thinking/reasoning
- Patterns in practitioners’ interactions with the organisational management system
- Patterns in practitioners’ interactions with assessment tools
- Patterns in family/whānau intergenerational experiences
- Patterns in client/family interactions with practitioners
- Patterns in victim/perpetrator interactions with informal support networks

Drivers
- Leadership
- Organisational priorities
- Resource constraints

Drivers
- Government priorities
- Funding constraints

Patterns in the provision of services
Patterns in communication and collaboration in multi-agency working and assessment

These patterns can interact in either direction (positive or negative)

Emergence
Death

Drivers
- Historical trauma
- Marginalisation
- Adverse childhood experiences
- Socioeconomic circumstances

Drivers
- Government priorities
- Funding constraints
Reports and recommendations....

Complex
the relationship between cause and effect can only be perceived in retrospect
probe – sense - respond
emergent practice

Complicated
the relationship between cause and effect requires analysis or some other form of investigation and/or the application of expert knowledge
sense – analyze - respond
good practice

novel practice
no relationship between cause and effect at systems level
act – sense - respond

best practice
the relationship between cause and effect is obvious to all
sense – categorize - respond

Chaotic

Simple

© Cynefin framework by Dan Snowden
A fragmented, siloed and unsafe family violence response system

- Parallel practice
- Collaborative practice
- Multidisciplinary practice
- Consultative practice
- Coordinated practice
- Interdisciplinary practice

Risk & complexity of needs increases

Current individual safety response

Risk & complexity of needs decreases

Current interagency safety response

Imagined - integrated safety responses

Requires:
- integrated system infrastructure to be in place
- practice principles that underpin all integrated system responses

This will require:
- different / new ways of working
- different / new sets of skills
- multiple practice models

Safety planning with victims

FVIARS

Family Safety Teams

Children’s Teams
Mindset shifts
Language matters

**Incident** = a distinct or definite event

**Episode** = part of a series of events

**Primary victim / predominant aggressor** = role in the abuse history of the relationship

**Cumulative harm** = patterns of victimisation and/or perpetration
Reconceptualising family violence

The language of empowerment


Victim blaming – responsible victims and invisible abusers
Empowerment can conceal victims’ resistance

A person's resistance does not and most often cannot stop violence but is no less important for that fact.

A mother who is being abused cannot and should not be held responsible for the violence and its cessation.
Reconceptualising family violence


IPV & CAN: entangled forms of abuse

‘a **double level of intentionality**: an act directed towards one individual is at the same time intended to affect another or others’  

(Regan 2001)

- hitting/threatening a woman in front of her children
- killing a child, in retaliation for the mother leaving

Regional reviews:
- threatening and assaulting women whilst they are holding young children
- strangling pregnant women

family violence ➔ a pattern of coercive control ➔ that actions directed at one individual are not necessarily designed to impact only on that individual.

What is your sphere of influence?

Effective social responses to family violence create safety and restore dignity.

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Issues and Challenges for Family and Domestic Violence Fatality Review Jurisdictions and Child Protection Agencies

Dr Nicole Leggett
Department for Child Protection and Family Support, Western Australia

Government of Western Australia
Department for Child Protection and Family Support
PERPETRATOR ACCOUNTABILITY IN CHILD PROTECTION PRACTICE

Dr Nicole Leggett
Manager Family and Domestic Violence Unit,
Department for Child Protection and Family Support
Family and Domestic Violence Unit

Department for Child Protection & Family Support, Family & Domestic Violence Unit is responsible for:

• across government and community sector family and domestic violence strategic planning; and
• developing and implementing family and domestic violence practice guidance for Department staff.
Western Australia’s Family and Domestic Violence Prevention Strategy to 2022 aligns with the National Plan and provides an overarching long term framework for responding to family and domestic violence.

Western Australia’s Family and Domestic Violence Prevention Strategy to 2022

WA Strategic Plan for Family and Domestic Violence 2009-2013

Establishing Change: building a solid foundation and facilitating an environment for change to 2013

Sustaining Change: strengthening the foundation and supporting further reform (2013-2016)

Consolidating Change: recognising achievements and assessing results (2016-2019)

Achieving Change: continuing reform beyond the life of the Prevention Strategy (2019-2022)

Primary State Outcomes to 2022

1 – PREVENTION & EARLY INTERVENTION
Individual attitudes and behaviours within the community reflect that family and domestic violence in any form is not acceptable.

2 – SAFETY FOR VICTIMS
Adult and child victims are safe and kept free from harm through timely and accessible services.

3 – ACCOUNTABILITY FOR PERPETRATORS
Perpetrators are held accountable for their actions and are actively supported to cease their violent behaviour.
Violence perpetrated by men towards their intimate partner and children is one of the main reasons that children and families are brought to the attention of the Department.

**Referral pathway WA Police: January – June 2014**
- 18,894 domestic violence incidents attended by police
- 12,342 involved children (65%)
- 3,333 related to open cases
- 2,949 required further child protection assessment
- 43.4% related to families were there had been multiple domestic violence incidents (between January 2013 – June 2014)
- 31.7% related to families who had been subject to ‘other’ child protection referrals (between January 2013 – June 2014)
Family and domestic violence policy position

<table>
<thead>
<tr>
<th>Aim of child protection intervention</th>
<th>Safety of adult and child victims is paramount: the safety of the child is linked to the safety and wellbeing of the adult victim.</th>
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<tbody>
<tr>
<td>Response framework</td>
<td>Perpetrator accountability: victims of FDV can only be considered safe if the risk posed by the perpetrator is managed or mitigated.</td>
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<tr>
<td>Child protection practice</td>
<td>Collaboration: victim safety and perpetrator accountability is best achieved through a coordinated and collaboratively response between agencies and with families - the system matters.</td>
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</table>
A mother (Melissa) of two children under the age of two has separated from her defacto partner who is the father of the children (Dave). Melissa has a violence restraining order and is living independently with the children.

The Department has concerns about the risks posed by Dave to Melissa and the children. Dave’s use of violence and abuse has been escalating and includes breaking into the house, assaulting Melissa, making threats to kill, attempted strangulation and making threats with weapons. The Department has no concerns about the protective capacity of Melissa.

At the end of a 12 month engagement with the Department, Melissa’s children have been brought into care and placed with her sister. Melissa is living with her sister and the children, and has forfeited her Department of Housing house. The rationale for protective intervention was related to the danger posed by Dave.
Case scenario – what went wrong?

• The focus of the Department’s involvement was working with Melissa to increase her capacity to keep the children safe.

• At no point did the Department, or any agency, engage with Dave or target activities at managing his use of violence.

• The Department and the other agencies involved in the case worked in isolation of one another.
Unintended outcomes of not working within a framework of perpetrator accountability

- Women and children:
  - are at continual risk of further violence and abuse;
  - are held responsible for managing their own safety; and
  - can be subjected to a punitive response when they are not successful.

- Perpetrators of violence continue to use violence unchallenged.

- A message is sent to clients and the community that men are not responsible for their use of violence.

- Family and domestic violence in unabated in the community, creating a revolving door.
Paradigm shift

<table>
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<tr>
<th>Impact on children</th>
<th>Complicating factor</th>
<th>Harm</th>
</tr>
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<tbody>
<tr>
<td>Philosophy</td>
<td>Protectiveness</td>
<td>Risk / Danger</td>
</tr>
<tr>
<td>Person responsible</td>
<td>Mother (adult victim)</td>
<td>Father (perpetrator)</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>Child focused</td>
<td>Child / adult victim</td>
</tr>
<tr>
<td>Response</td>
<td>Single agency</td>
<td>Collaborative response</td>
</tr>
</tbody>
</table>
Perpetrator accountability in practice

• Identifying family and domestic violence (screening)
• Positioning of the case and the assessment
  – risk and behaviour focused, clear & specific, **who has done what to whom and with what impact**;
  – understanding when and how protective behaviours mitigate risk; and
  – gathering information from the adult victim and other agencies involved in the case – privileging the story of the adult victim.
• Engaging the perpetrator
  – clear and specific about our concerns, assessment of readiness/willingness to be a safer parent (using violence is a parenting choice); and
  – safety planning and supporting change (if possible).
• Managing risk
  – engaging a safety network including family and professionals to increase safety and manage risk. Risk is managed through multi-agency risk assessment and safety planning. The goal is to use all available systems, processes and resources to contain or reduce the risk.
Perpetrator accountability in practice: critical context

- Shared responsibility for responding to family and domestic violence
- Information sharing
- Commitment and relationships at all levels
Practice led policy

• Reviewing cases provides an opportunity for the Department to evaluate the adequacy of policy and procedure (and/or their implementation) for supporting workers to respond to family and domestic violence.

• Case reviews also support the identification of systemic issues that can be addressed through strategic planning.
Case scenario two - same scenario, different ending

The Department:

- Engages with Dave. Purpose: to outline concerns about his use of violence; assess his willingness/ability to be a safe parent; and if appropriate, offer referral to a men’s behaviour change program.
- Substantiates harm and identifies Dave as the person responsible.
- Engage family in creating a safety network.
- Convene multi-agency case management which results in the reduction of risk:
  - Police charge Dave with breach of VRO and assault, provide a duress alarm to Melissa, place an alert on the property;
  - Safe at Home and Department of Housing install safety provisions at the property (dead bolts, security screens, cameras, alarm);
  - Safe at Home provide ongoing outreach including case management and support to Melissa;
  - Department of Housing forgive debts related to property damage;
  - Dave pleads guilty to the charges and is deferred to family violence court; and
  - ongoing information sharing supports detection of further acts of violence, which instigate police response including breach of bail conditions.
Other examples…

• The Department receives allegations of child abuse from a father in relation to his former partner. The Department determines that the claims are vexatious based on the information provided by other agencies.

• A high risk domestic violence perpetrator has been arrested and bailed. One of the conditions of bail is that he resides with his partner and children (the victims of violence). The Department works with the family, police and court based family violence service to develop an argument for the magistrate about why bail conditions should be amended and to establish as much safety as possible in the mean time.

• An incarcerated offender is making threats to kill his partner from prison. Threats have been communicated via phone and family members. Corrective services notify the Department and police, they work together, with FDV support services, to pursue charges against the perpetrator and in the event he is released, to plan his release.
Challenges: *work in progress*

- Sustaining the paradigm shift.
- Supporting staff, partner agencies and families to understand and support an accountability focus.
- Behaviour change is a long term process.
- The person using violence has to want to change (internal or external drivers).
- The work of the Dependent is impacted by the outcomes delivered in other components of the service system, and vice versa.
- The overarching capacity of the service system to contain (or stop) a man who is using violence.
What worked

• Using practice based evidence to influence change
  – safety and accountability audit (praxis);
  – homicide review; and
  – case reviews.
• Working across the organisation at all levels.
• Sustained focus and consistent messages.
• Case based examples.
• Working closely with partner agencies.
• Alignment of across government strategic planning to the policy and practice position of the Department.
NSW DOMESTIC VIOLENCE DEATH REVIEW TEAM

Presented by:
Anna Butler
NSW Domestic Violence Death Review Team Manager
DVDRT Establishment, Structure and Methodology

- Established under the *Coroners Act 2009 (NSW)*
- Reviews domestic violence homicides on the basis that such deaths are considered to be *predictable* and therefore *preventable*
- Team comprises a *multi-disciplinary* committee from Government and non-Government sectors
- Core functions: analyse dv related deaths; identify patterns and trends; and develop recommendations and undertake research to prevent or reduce the likelihood of dv related deaths
- Scope of review includes homicides, suicides and accidents that occur in the context of domestic violence
- Reports annually to NSW Parliament
Case identification and categorisation

Homicide occurs on or after 1 July 2000

Inquest/prosecution finalised - case closed -

Intimate partner homicide

Relative or kin homicide

‘Other’ homicide

Death occurred in a dv context

Death did not occur in a dv context

Death occurred in a dv context

Death did not occur in a dv context

Death occurred in a dv context

Death did not occur in a dv context

Unknown
All child homicide victims
1 July 2000 - 30 June 2010
N = 109

Child homicide victim perpetrator identified
N = 99

Child homicide victims killed
Domestic relationship with perpetrator
N = 78

Child homicide victims killed
Domestic relationship with perpetrator
AND domestic violence context
N = 56

Child homicide victims killed
- No domestic relationship with perpetrator
AND domestic violence context
N = 22

Child homicide victims killed
- No domestic relationship with perpetrator
NO domestic violence context
N = 0

Child homicide victims killed
- No domestic relationship with perpetrator
NO domestic violence context
N = 21
In-depth case review

Homicide occurs on or after 1 March 2008

Inquest/prosecution finalised - case closed -

Intimate partner homicide
- Death occurred in a dv context
- REVIEWED

Relative or kin homicide
- Death occurred in a dv context
- REVIEWED

‘Other’ homicide
- Death occurred in a dv context
- REVIEWED

Unknown
- Death did not occur in a dv context
- REVIEWED

Death did not occur in a dv context
Recommendations

• Specific recommendations designed to improve agency responses to domestic violence (for example, addressing management of child custody issues within NSW Police) and broad recommendations which examine domestic violence holistically.

• Proposed recommendations in relation to trauma-informed programs for parents.

• Proposed recommendations in relation to responding to and addressing intergenerational trauma.
Challenges/Future Directions

• Measuring success
• Challenges around qualitative analysis
• Implementation of recommendations/monitoring
• Challenges inherent in multi-agency review processes
• Expanding review model into accidents and suicides
NSW DOMESTIC VIOLENCE
DEATH REVIEW TEAM

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