Submission in response to the proposed Early Years Strategy

Parkerville Children and Youth Care (Parkerville CYC) welcomes the development of a Strategy to help the Commonwealth create a more integrated, holistic approach to the early years and better support the education, wellbeing, and development of Australia's children.

Please accept this submission on behalf of Parkerville Children and Youth Care. We acknowledge the stories and lived experience of the people we serve: in developing this submission, we have illustrated points with detailed current case or practice examples. To protect the privacy of those involved, and given the level of detail in the case studies (to demonstrate the complexity and intersecting issues for the people we serve), we have submitted two versions. The version provided here does not include the case study examples, and is therefore suitable for publication.

Acknowledgement of lived experiences of violence and abuse

Parkerville CYC acknowledges the lives and experiences of the children, young people and families represented in this submission who are affected by all forms of child abuse, and domestic, family, and sexual violence. We recognise their individual stories of courage, hope and resilience, and that of all victim-survivors.

Introduction

Early childhood is one of the most significant periods of human growth, critical in determining physical, social and emotional, behavioural and cognitive development in ways that can have lifelong impacts on health and wellbeing. We have a good understanding of the risk factors that can threaten children's development, and we know that intervening early can reduce risk factors and increase protective factors in a child's life. As we know, the true measure of a society can be determined by the way it treats its most vulnerable. The critical challenge, then, becomes having the political and community will to act for children in their early years.

This requires more than a focus on early childhood initiatives – though vital. It necessitates a more strategic and coordinated approach that recognises how child abuse and maltreatment, alongside child poverty, inequality, family violence, intergenerational trauma and other systemic harms, shape early childhood for many Australian children. There is nothing more damaging to wellbeing and whole of life

1 Watertank Way, Midland 6056 | ABN 86 437 092 401
(08) 9235 7000 www.parkerville.org.au

outcomes than growing up in poverty, in insecure and abusive homes and communities, and with unequal access to essential and specialist services. It is imperative to have a whole-of-Government approach that recognises this context and the profound impact on children in the early years, and as they develop throughout childhood, adolescence and into young adulthood.

In our submission, we focus particularly on questions 4, 5 and 6, with suggestions for policy priorities, how to improve outcomes for children raised in more vulnerable and disadvantaged circumstances, and areas for improved service and policy coordination and collaboration. We also speak to the broader Commonwealth strategic agenda regarding children and families affected by disadvantage and abuse, as reflected across a series of Strategies, National Plans and national/international commitments. Few of these adequately acknowledge or address the early years.

Our holistic support to children, young people, and families

Parkerville CYC is a For Purpose organisation that supports children, young people, and their families to build skills and capacity, address the impacts of trauma and adverse childhood experiences, and develop capabilities that will enable them to be the best versions of themselves. We see a future where Western Australia is the safest place in the world and all children, young people, and their families feel safe to dream, to thrive, and to reach their fullest potential. We have been working alongside vulnerable children, young people, and their families for 120 years, and every year, we support more than 13,000 people across WA through our therapeutic, out of home care, youth, and education services. The future of those we serve depends on what we do in the present to support them to reach their potential.

In the past 12 months, Parkerville CYC has:

- Supported 1,280 children presenting with disclosure of child sexual abuse, through our Multiagency investigation Support Team (MIST) services that are delivered in partnership with the WA Police Child Abuse Squads in Armadale and Midland
- Helped 1,142 families through intervention and ongoing support after experiencing abuse
- Supported 140 children and young people who are experiencing complex trauma through specialised Protective Behaviours Education and person centred safety planning
- Supported 417 children and young people with Clinical and Therapeutic Services
- Provided a safe place to live to 222 children and young people in our Foster Care, Family Group Homes, and Youth Crisis and Supported Accommodation
- Supported 123 children, young people and families through our outreach programs:
    - 58 families through the Support and Community Services program that assists families with children in their care who are experiencing homelessness
    - 37 young people and families through the Reconnect (Youth Diversion from homelessness) program
    - 28 young people through the Moving Out, Moving on program where living at home with family is not a safe or possible option.
- Held 10,141 Early Intervention sessions at our Child and Parent Centres (CPCs)
- Supported 25 high educational risk with complex trauma and mental health needs Education, Employment and Training students to graduate

Parkerville CYC's support for children, young people, and families

Education, Parenting and family services

- **Child and Parent Centres (CPCs):** Parkerville runs two CPCs in Perth, servicing 12 primary schools in vulnerable communities. The centres work to create an entry point into the school systema and help with school readiness, but importantly they focus on increasing family capacity and help them provide appropriate developmental experiences and a happy, healthy home.
- **Education Employment and Training Program (EET)**: For young people at extreme educational risk as a result of trauma, mental health and/or family issues

Services for children, young people and families affected by homelessness

- **Support and Community Services (SACS):** service for families with children aged 4-14 that are experiencing homelessness, or at risk of homelessness and living in supported accommodation.
- **Moving Out, Moving On (MOMO):** service for young people aged 15-21 who are experiencing homelessness, or at significant risk of homelessness or transience.
- **Reconnect:** a diversion and early intervention service for families with young people (12-18) at risk of homelessness or family breakdown.
- **Yong Women's Program:** medium-term accommodation and support for young women (including those with children) aged 16-25 experiencing or at risk of homelessness, or who need help to live independently.
- **Armadale Youth Accommodation Service (AYAS):** short-term crisis accommodation for young people experiencing/at risk of experiencing homelessness.

Our support for children affected by child sexual abuse (CSA)

- **Multi-agency Investigation and Support Team (MIST):** co-located, multi-disciplinary, trauma-informed model to reduce harmful impacts of trauma from abuse. WA's first truly integrated child sexual abuse (CSA) response, with Child Advocacy Centres in Armadale (2011) and Midland (2019), and Child and Family Advocates (CFA) and psychology services attached to the Perth District Child Abuse Team (2020). MIST's core principle is to reduce instances of children having to tell and re-tell their story, and coordinate services (including Police) to wrap around the child and family, through collaborative relationships and knowledge-sharing.
- **Therapeutic Services:**
  CSATS: We provide a Child Sexual Abuse Therapeutic Service (CSATS) in a regional area of WA.
  PACTS: We also provide a Parents and Children's Therapeutic Service (PACTS) in a northern Perth suburb. 84% of children and young people receiving a service had experienced child sexual abuse.

Out of Home Care

- Parkerville CYC cares for 126 children and young people across foster care, family group homes (FGH) in the Metro area and in the Murchison. We also run an intensive residential program for young people aged 12-17 currently under the care of the Department of Communities (Belmont Youth Program). We are implementing an innovative new model (Our Way Home) – radically personalised shared care: focusing on the needs and desires of each child, and deliberately seeking to establish, maintain and deepen connections between children and their families.

Note on Child Maltreatment

By definition, child maltreatment is caused by caregiving behaviours that impede a child's development through physical or psychological harm, or neglect of a child's needs. Whilst intervention to address maltreating behaviours is critical, we know that they are predicted by additional and compounding risks, i.e., there is no single cause of child maltreatment; it is 'multidetermined' by a combination of risks existing at the level of the child, family, community, and society (Asmussen *et al.*, 2022).

All the children that we serve have been affected by child maltreatment in some way. In many cases, their experiences encompass multiple forms of maltreatment, resulting in complex trauma and the need for intensive and/or multiple service intervention. The evidence that we present below draws on our practice experience with children under 5, children over 5 who needed but did not receive necessary/sufficient early intervention, and young people with multiple and complex needs who we have supported during pregnancy and/or their child's early life. Our recommendations are informed by walking alongside and working in support of vulnerable children, young people, and their families, and with a clear understanding of the complexity and systemic challenges which create, explain, and enable child maltreatment in the early years, and across childhood and adolescence.

Recommendations

1. Pregnant people should not be in prison. There must be greater use of community-based sentencing: intensive stressors of the prison environment inevitably impact detrimentally on the developing foetus, contributing to poor parental and neonatal outcomes.
2. Design ante- and post-natal service responses that are agile, and able to deliver outreach assessment and intervention to pregnant people experiencing homelessness and/or other multiple and substantial service access barriers (including FDV).
3. The early years agenda must engage with policy efforts to address housing insecurity and FDV. The Commonwealth Government's increased funding for the Safe Places Emergency Accommodation Program is welcomed, particularly its focus on improving access and cultural connection for First Nations and CALD women and children:
   a. flexibility must be built in, to meet families' diverse needs and including intensive, holistic (likely outreach) ante- and post-natal support for women in these circumstances.
   b. Locational disadvantage must be considered in the light of poverty-related impediments to accessing and remaining connected to services.
4. Raise awareness about ante- and post-natal care needs of trans and nonbinary people, particularly at the intersection of trauma, mental health, homelessness, and (lack of) access to safe universal services, and to specialist services.
5. Better resourcing for safe, inclusive (gender-affirming) supported and long-term housing for pregnant and postnatal trans people is urgently required.
6. Better coordinate existing universal services into a cohesive and integrated system which engages *all* families according to their preferences and needs: universal, targeted and specialist support for families.
7. Build high-level, multi-agency data/information sharing and routine analysis, to respond to population need and target resources where necessary. This should include expanding on an outcomes budget to include a child, youth, and family wellbeing framework.
8. Build the national evidence base about best practice in children's centre/hub models: knowledge is often necessarily developed and held at the local level, but an evidence-based national picture, with shared language and common metrics, would be welcome.
9. More resourcing should be directed towards engagement and awareness raising with disadvantaged families about what universal services offer, to increase take up, reduce isolation, and bolster early intervention. This should start antenatally.
10. Early intervention services located in safe accessible locations such as schools, like CPCs, must sit alongside specialist services for vulnerable groups, which can respond to particular community need in a targeted way. Such services must be well-resourced, and funding should respond quickly to changing community need.

11. The Early Years Strategy must speak to the National Plan to End Violence against Women and Children 2022-2032. To achieve the National Plan's overarching goal, children must be recognised as victim-survivors in their own right, with age-appropriate, specialised trauma-informed initiatives for children 5 and under.
12. Create integrated, priority referral pathways and outreach models for families in crisis and/or recovering from trauma, who are likely not in a position to meet rigid service criteria: flex the system to meet children/families where they are, not where the system thinks they should be, so that children's early developmental needs are better supported.
13. Prioritise access to early education services for children experiencing homelessness or other structural barriers, given the likelihood of missed early education participation, resulting negative developmental impacts, and poor provision of treatment options and support; and role of early education settings as safe, stable environments for young children experiencing instability and crisis.
14. The Early Years Strategy must speak to the First Commonwealth Action Plan to Prevent and Respond to Child Sexual Abuse (CSA), to develop a more robust and integrated evidence base and response to CSA in the early years. This should include:
    a. Awareness-raising efforts that include information tailored and developmentally appropriate for under 5s: recognising signs of CSA in younger children, responding to CSA disclosure and/or concerns, how to talk about safety, body autonomy and consent
15. Priority pathways to child developmental services for children 0-5 who have experienced CSA should be considered, recognising the significant impact of CSA on child development and negative lifelong outcomes.
16. The Early Years agenda must engage with Commonwealth-led efforts on harmful sexualised behaviours (HSB), to ensure that the needs and particular harms for children 0-5 are clearly articulated/understood:
    a. Commitment to primary prevention of HSB through a multi-agency public health approach is welcome. This should include greater research into, and understanding of, both the incidence and impact of HSB on under 5s.
    b. Commitment to secondary prevention of HSB where behaviours are developing/at greater risk of developing – such as in out of home care - is welcome. However, the continuing placement of children 5 and under in group residential care alongside older children at very different developmental stages, is not conducive to this aim.
17. Develop national guidance, with common terminology, about the specific development needs of under 5s with complex trauma; how their trauma and ACE histories impact on development during this crucial window; and how targeted and holistic intervention support can/should be accessed to mitigate impact of trauma and support positive developmental outcomes.
    a. This should be informed by a clear narrative of child outcomes at key life course points such as birth, entry to learning (age 2–3) and entry to school.
    b. This should be targeted towards all professionals working with this cohort (early and primary educators, healthcare, all child development services, etc.)
    c. This should also be inclusive of intensive family supports to enable them to address family functioning issues that impede creating safe healing contexts for children.

18. Prioritise access to early educational environments for children 5 and under in care:
    a. Pre-school early education access should not be case-by-case, at departmental discretion. All children 5 and under in care, whatever their placement type, or geographical location, should be guaranteed a minimum number of hours in early childhood education, per Standard 6 of the National Standards for out-of-home care.
    b. Individual learning plans should be part of care planning for all children coming into care, including children 5 and under, outlining how developmental and educational outcomes at key life course points will be met, with resourcing attached.
19. Develop a standardised framework for building cultural connection and family connection for under 5s, recognising the significance of maintaining and championing family and identity as part of early childhood development, given its lifelong impacts on wellbeing.
20. The impact of placement type on developmental outcomes for under-5s should be considered as a matter of priority, recognising that residential group homes are rarely the appropriate environment for young children. Maintaining sibling connection must be prioritised, but balanced against developmental needs for children 0-5.
21. Better resourced and more intensive leaving care support should be a national priority. Within this, Government must re-focus efforts on more intensive, holistic multi-agency support for care leavers who become pregnant, to support optimal outcomes for baby and parent, including determined efforts to ensure stable and long-term housing, and building parenting capacity to break the cycle of repeat, inter-generational child removal.

1. Antenatal and postnatal health and care

Pregnancy presents a critical moment to support parents to build a positive relationship with their children. Research shows that parents are particularly receptive to advice and support at that time. A focus on the first 1000 days needs to include more consistent, evidence-based antenatal education as a universal offer. But further, there needs to be more comprehensive and intensive support for vulnerable parents. Experiences during pregnancy can, in turn, affect the developing foetus (Mueller and Tronick, 2019). A child under one is over three times more likely to have poor general health if the mother has poor general health in the year after giving birth. If the mother has a chronic condition during pregnancy, there is a 30 percent increased risk of that child also having a chronic condition in their first year of life.

Exposure to high-stress contexts during pregnancy increase maternal cortisol along with a downregulation of the enzyme can result in more cortisol reaching the foetus, which can lead to changes in behavioural development (Ramborger *et al*., 2018), a larger infant cortisol response, a slower rate of recovery after experiencing a stressor (Davis et al., 2011), as well as make the infant more susceptible to stress later in life.

Parkerville CYC does not provide antenatal care/services specifically related to pregnancy. However, we are supporting, or have supported, people during pregnancy and postnatally across our services. The following recommendations are informed by evidence from practice and the experiences of the young people we serve who are/have been pregnant or have babies during their support period with Parkerville.

Recommendations

1. Pregnant people should not be in prison. There must be greater use of community-based sentencing: intensive stressors of the prison environment inevitably impact detrimentally on the developing foetus, contributing to poor parental and neonatal outcomes.
2. Design ante- and post-natal service responses that are agile, and able to deliver outreach assessment and intervention to pregnant people experiencing homelessness and/or other multiple and substantial service access barriers (including FDV).
3. The early years agenda must engage with policy efforts to address housing insecurity and FDV. The Commonwealth Government's increased funding for the Safe Places Emergency Accommodation Program is welcome, particularly its focus on improving access and cultural connection for First Nations and CALD women and children:
   a. flexibility must be built in, to meet families' diverse needs and including intensive, holistic (likely outreach) ante- and post-natal support for women in these circumstances.
   b. Locational disadvantage must be considered in the light of poverty-related impediments to accessing and remaining connected to services.
4. Raise awareness about ante- and post-natal care needs of trans and nonbinary people, particularly at the intersection of trauma, mental health, homelessness, and (lack of) access to safe universal services, and to specialist services.
5. Better resourcing for safe, inclusive (gender-affirming) supported and long-term housing for pregnant and postnatal trans people is urgently required.

1.1 Multiple disadvantage and maltreatment in antenatal and postnatal period

We see a high degree of current, previous, and intergenerational complex trauma amongst the women, girls, and pregnant/post-natal people that we support in our services. In our outreach services for children, young people and families affected by homelessness, we have supported pregnant women fleeing domestic violence with their children, experiencing extreme stress and physical threat both to themselves and, by default, their unborn child. The consequences can be significant: women who experience violence during pregnancy are more likely to suffer complications in pregnancy, birth and post-partum and are more likely to experience depression, trauma, and anxiety; DV increases the risk of miscarriage, infection, premature birth, and injury/death of the baby (Campo, 2015a). Increasing evidence indicates that FDV during pregnancy and the perinatal period is associated with poor health outcomes for the foetus, newborn, and infant up to 1 year postpartum; and that FDV has a 70-80% incidence of recurring during the first year postpartum when at least one incident of FDV was reported during pregnancy (Mueller and Tronick, 2019).

We have also supported pregnant transgender young people in our youth services, who have many of the same challenges as other pregnant people, but experience pregnancy in the context of a society that largely understands it as something that women do, and can struggle to adjust language, expectations, and interactions accordingly, to meet transgender people's needs. Given this context, it is crucial to provide individualised care, use affirming language and practice, and model this to other agencies in advocacy for trans young people navigating services that they may experience as gender-insensitive or non-inclusive of their needs and experiences. For pregnant and post-natal trans people accessing our services because of trauma and crisis, this includes barriers to suitable supported accommodation services (i.e., for individuals with babies/young children) due to referral criteria that specify women only.

Case Study: pregnancy, youth justice and complex trauma
Redacted

Case Study: in utero/postnatal FDV and insecure housing
Redacted

2. Child Development: impact of poverty, inequality, and child maltreatment

Here, we address child development in the early years at the intersection of poverty, inequality, and child maltreatment. We know the vital importance of the first 5 years. We also know that for many children, their development is multiply and severely constrained very early – for some, even before birth. The reasons are often complex, a combination of familial, community and structural factors and inequalities (such as locational disadvantage) that cannot be isolated from each other.

One in every five Western Australian children starts school with at least one area of developmental vulnerability (CoLab Partnership, 2020). In most instances, this represents a failure of early intervention, and one that particularly affects children affected by trauma and multiple disadvantage. As the family stress model outlines, poverty is inextricably linked to this: hardship creates economic pressure. Pressure leads to psychological distress, the emergence of mental health issues and damaging coping behaviours (such as excessive alcohol consumption) and, in turn, to relationship problems and disrupted care-giving and, finally, to problems in children's development and adjustment; within the context of a wider public culture of stigma and shame around poverty and welfare. In sum, structures exist which keep many families without the resources necessary for healthy child development (Bywaters *et al.,* 2022).

At the macro level, Government efforts should be directed towards policies that cut family poverty – particularly deep and persistent poverty. At the level of service provision, there is no single solution to reducing the impacts of disadvantage on child development. Consequently, the appropriate approach seems to *have a sequence of strategies that envelop or scaffold child development,*[1] inclusive of an overarching framework, such as a child, youth, and family wellbeing framework within which to distribute resources and measure impacts across the lifespan.

[1] CoLab Partnership: Early Years Initiative www.earlyyearspartnership.org.au

We often support children and families during intensely traumatic and complex circumstances, and rather than singular instances, often this trauma and complexity is deeply embedded, recurring, and inter-generational (regardless of cultural or other demographic markers). As noted above, families experiencing and/or recovering from this level of trauma and complexity need a service response that envelops them; one equipped to respond to crisis **and** ensure that the crucial developmental needs of children are not overlooked, but rather given special focus exactly because of the impact that crisis, trauma, and complexity can have on child development and family functioning during this crucial window.

Our focus in this submission is particularly on:

- **High quality, *accessible* and *affordable* universal services** as essential to giving the best possible start for all children, catering for evolving needs as children develop and family circumstances change. *Accessibility* and *affordability* are critical concerns for the children and families that we support, with particular issues around locational disadvantage, wait lists and availability as notable barriers to more disadvantaged children and families, particularly given the developmental impact of failure of early identification of potential risks or developmental issues. This can be even more true for families who may otherwise remain unknown to services. Indeed, service utilisation is lowest among families with the greatest needs (CoLab Partnership, 2020). We provide evidence from practice, including case studies, below.
- Imperative for a 'proportionate' approach, i.e., **tailored, well-resourced additional support for children and families with greater needs.** Additional supports should be available according to the level from which the additional need arises within a primary health step-up and step-down service framework – at the level of the child, the family, or the community – noting that these circles are inter-related and that strengths or adversity at one level rarely occur in isolation of one (or both) of the others. Child and Parent Centres are strong examples of community-focused, place-based concentration of universal, multi-disciplinary services and community programs to better support early identification and intervention.

2.1 Child and Parent Centres: bringing universal and specialist provision together

Recommendations

6. Better coordinate existing universal services into a cohesive and integrated system which engages *all* families according to their preferences and needs: universal, targeted and specialist support for families.
7. Build high-level, multi-agency data/information sharing and routine analysis, to respond to population need and target resources where necessary. This should include expanding on an outcomes budget to include a child, youth, and family wellbeing framework.
8. Build the national evidence base about best practice in children's centre/hub models: knowledge is often necessarily developed and held at the local level, but an evidence-based national picture, with shared language and common metrics, would be welcome.
9. More resourcing should be directed towards engagement and awareness raising with disadvantaged families about what universal services offer, to increase take up, reduce isolation, and bolster early intervention. This should start antenatally.
10. Early intervention services located in safe accessible locations such as schools, like CPCs, must sit alongside specialist services for vulnerable groups, which can respond to particular community need in a targeted way. Such services must be well-resourced, and funding should respond quickly to changing community need.

Ensuring access to high-quality local family services which start in maternity and run throughout childhood is fundamental to improving equality of opportunity and providing a safety net for children and families. CPCs are a crucial part of this: they are universal in ambition, but with a priority focus on (1) enabling connection with an educational developmentally-focused environment that aids in the identification of impediments to the smooth transition to schooling, (2) reducing inequalities and supporting vulnerable children and families particularly, and (3) providing access to place-based specific services (wrap around services and supports that address developmental, social familial, and structure issues such as poverty). They are place-based and co-designed with community – resulting in a responsive and agile service delivery model as far as they are able. Some, such as the ones Parkerville provides, also provide access to education, specialist services and supports that address FDV for example, as this is a major presenting issue.

Periods of change in families' lives, such as pregnancy or a bereavement, can all contribute to more stress, which can in turn lead to parental conflict. These points in time are when families may have contact with a CPC and as such, they present an opportunity to identify parents, children and young people who may be experiencing challenges and to offer appropriate support. Whilst a focus on parent/carer-child relationship and building parenting capacity is therefore vital, it is equally important to recognise family and community context as crucial factors that support or inhibit a child's early development.

Our two CPCs are in areas designated as having high socio-economic disadvantage, and serve diverse communities, with our Gosnells-located CPC in particular serving a community that is approximately 85% CALD. Our approach to best supporting the children and families is place-based, culturally sensitive and trauma-informed. This is particularly critical given the deep distrust that some CALD

communities that we serve express towards Government services, including health. We take great care to build this trust and act responsively to community need, including by co-locating with allied health services to embed early intervention services in communities. The CPCs have an average monthly attendance of between 375 and 500 people, and run a variety of playgroups primarily targeting children 5 and under (including for babies, pre-kindy, neurodiverse children, young parents, and fathers/father figures). They host developmental services, including a Child Health Nurse (CHN), Speech Pathologist, lactation consultant, immunisation clinic, kindy screening and parenting groups.

Evidence from practice: key findings

Our work with families who may have various vulnerabilities, including social isolation and socio-economic disadvantage, demonstrates the necessity for early intervention. We find that for vulnerable families, this is best achieved through a constellation of programs that build capacity and community; removing any stigma around or reluctance to seek help by creating a safe, open environment that wraps early intervention support around families.

1. **Place-based, targeted support to families**

   Capacity and confidence to access support is not universal to all families in our community. Some local families distrust health and/or government organisations, and the CPC may be the only service with which they meaningfully engage (see Case Snapshot, below). For some families from CALD communities, counselling support is often associated with a stigma of weakness. This is also true regarding disclosure of intimate partner/family violence and control. The WA Department of Communities have reported to our Local Advisory Committee that they have been seeing a higher prevalence of CALD families presenting with FDV, and this is our daily experience also. We provide social support, a safe environment, awareness-raising primary prevention materials and maintain close relationships with specialist CALD organisations, to facilitate support when women experiencing FDV feel prepared to reach out for help. And crucially, our CPCs' grounding in the community and range of supports helps to build social capital and community connections, a vital contribution to reducing isolation and supporting help-seeking. We work with families to build their trust in us, and thereafter, trust in the benefits of accessing support to help them fully thrive with their families into the future. This requires an approach that is more flexible and responsive than the wider system generally allows. The fact that abusing partners will 'allow' access to educational contexts without over-solicitous tracking of movement, enables significant opportunities for engagement, information provision and connection to supports.

2. **Flexible, wrap around care to support early intervention**

   Our CPCs create a flexible, multi-agency environment: the onsite Child Health Nurses, Occupational Therapist and Speech Pathologist can sit in on sessions, observe children, and make referrals if required (the challenges around wait lists remain the same, however: up to 2 years to access OT services due to high demand and a shortage of practitioners, and up to 14 months for Speech Pathology appointments). Sessions that are responsive to need, such as regular drop-in speech pathology sessions for families to discuss concerns about child speech development and ask about referrals, or neurodevelopmental support groups, build parental confidence about home interventions, and hold families in a safety net while they wait for appointments.

3. **Building parental capacity and community integration**

   We observe a notable degree of poverty/increased financial distress with increasing cost of living pressures, social isolation amongst families attending our CPCs, particularly for CALD and/or

migrant families. We support these families by creating a social setting in which they can practise the skills they learn at the CPC without fear of judgment, prejudice, or the pressure of assessments; and access referrals and supports to help them address mental health, food security and financial distress. This contributes to building a sense of community, reducing isolation, increasing parental confidence around proactive engagement with their child's development, and reducing negative risks or factors, such as fear about money/rent payments/food, that are closely associated with higher incidence of FDV events as well as other maltreatment concerns.

A responsive approach to community need has also enabled us to promote best practice around LGBTQIA+ inclusion in the early years sector: consulting with our LGBTQIA+ families to create safe and welcoming spaces, provide meaningful resources, signpost to LGBTQIA+-friendly early education settings, and use research-informed practice to ensure that every child and family feels valued and included in our services.

Case Snapshot

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Case Snapshot

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2.2 Impact of family violence and multiple disadvantage

Recommendations

11. The Early Years Strategy must speak to the National Plan to End Violence against Women and Children 2022-2032. To achieve the National Plan's overarching goal, children must be recognised as victim-survivors in their own right, with age-appropriate, specialised trauma-informed initiatives for children 5 and under.
12. Create integrated, priority referral pathways and outreach models for families in crisis and/or recovering from trauma, who are likely not in a position to meet rigid service criteria: flex the system to meet children/families where they are, not where the system thinks they should be, so that children's early developmental needs are better supported.
13. Prioritise access to early education services for children experiencing homelessness or other structural barriers, given the likelihood of missed early education participation, resulting negative developmental impacts, and poor provision of treatment options and support; and role of early education settings as safe, stable environments for young children experiencing instability and crisis.

All children deserve to be born into and grow up in safety. This includes a child's need to live in homes and communities that are free from family and domestic violence and the related ongoing patterns of behaviour that coerce, control, or create fear within a family.

Family violence creates both serious and cumulative negative psychological, emotional, and social impacts on child wellbeing that is lifelong and multifaceted. It also creates highly destabilising and traumatic secondary effects, including unstable housing, higher risk of experiencing poverty/food insecurity and the concurrent impacts of this, and little or no access to health, education, child

development services, and ante/post-natal care. It can also include extreme safety risks, most especially within a context whereby the time around leaving a violent relationship is the most dangerous for a victim-survivor and their children, requiring highly responsive, flexible, and trauma-informed service support. Exposure to FDV is child maltreatment in itself (UN Convention on the Rights of the Child, Article 19), and evidence shows that young children experiencing family violence can immediately struggle with empathy and other social skills, and form negative attachments to their parents (Fletcher and Stewart, 2022), as well as have lifelong impacts on wellbeing. Greater policy focus must be given to the profound impacts of FDV on child development in the early years, and especially considering the cost to personal and community outcomes.

In 2020–21, 7,102 children and young people aged 0 to 17 years presented at WA specialist homelessness services alone or with their families, the majority of whom (4,170) were under 10 years of age (AIHW, 2021). We know that FDV is the leading cause of homelessness for children (Campo, 2015b, Government of Western Australia, 2022). While FDV can affect anyone, regardless of culture, gender, economic status or sexuality, research and practice show that overwhelmingly, violence perpetrated by men against women is the most common. Consequently, women and children are at greatest risk of homelessness, as women leaving the home to establish greater safety for themselves and their children; with certain groups at even greater risk, including Aboriginal and Torres Strait Islander women and their children. FDV disrupts and violates the sense of safety and belonging within the home, but making the decision to leave usually results in losing the family home permanently. This loss itself can have traumatic effects on children (Spinney, 2013).

FDV is the driving cause of homelessness and residential transiency for the children and families that Parkerville CYC supports; both in terms of our whole family supports, and our services supporting children and young people fleeing violent homes into homelessness. We see the wide-ranging and highly destabilising impact of this in our Outreach services. In our Support and Community Services (SACS) program, the July-December 2022 period saw a notable increase in families actively fleeing violence and engaging with services to address imminent threat to themselves and their children.

Case Study

Redacted

2.3 Impact of child sexual abuse and multi-type child maltreatment

Recommendations

14. The Early Years Strategy must speak to the First Commonwealth Action Plan to Prevent and Respond to Child Sexual Abuse (CSA), to develop a more robust and integrated evidence base and response to CSA in the early years. This should include:
    a. Awareness-raising efforts that include information tailored and developmentally appropriate for under 5s: recognising signs of CSA in younger children, responding to CSA disclosure and/or concerns, how to talk about safety, body autonomy and consent
15. Priority pathways to child developmental services for children 0-5 who have experienced CSA should be considered, recognising the significant impact of CSA on child development and negative lifelong outcomes.
16. The Early Years agenda must engage with Commonwealth-led efforts on harmful sexualised behaviours (HSB), to ensure that the needs and particular harms for children 0-5 are clearly articulated/understood:
    a. Commitment to primary prevention of HSB through a multi-agency public health approach is welcome. This should include greater research into, and understanding of, both the incidence and impact of HSB on under 5s.
    b. Commitment to secondary prevention of HSB where behaviours are developing/at greater risk of developing – such as in out of home care - is welcome. However, the continuing placement of children 5 and under in group residential care alongside older children at very different developmental stages, is not conducive to this aim.

Our practice in supporting children, young people and families affected by child sexual abuse (CSA) demonstrates the profound impact of this trauma for the child, and non-offending family members. It should also be noted that the trauma of CSA is rarely the sole abuse experienced by children and young people. The Australian Child Maltreatment Study (released March 2023) has found that 4 in 10 young people aged 16-24 have experienced more than one type of abuse, with 25% experiencing 3-5 types. We see this consistently in practice. For instance, we supported 19 children in PACTS from 1 July-31 December but recorded 46 combined experiences of abuse (exposure to FDV, physical abuse, emotional abuse, sexual abuse), i.e., most children experienced multiple types of abuse, the highest incidence being for sexual abuse and exposure to FDV. Similarly, our CSATS program recorded 90 combined experiences of abuse for 44 children.

For all our services supporting children, young people and families affected by CSA, we see how entrenched poverty and multiple disadvantages, family complexity and intergenerational trauma intersect to create risk to children, and often differential risk according to sex, gender, ethnicity, and other facets of identity. At the family level, parents/caregivers may be emotionally or physically unavailable, may themselves be the perpetrator or minimise/justify the abuse, may have their own history of CSA and/or intergenerational trauma, and in cases of harmful sexualised behaviours such as sibling-perpetrated abuse (which continues to increase as a presenting issue in our services) – be managing a highly complex and traumatic intrafamilial situation. Indeed, many of our cases are within the family network: for clients in CSATS and PACTS, our most recent data shows that in 68% and 74% respectively of cases the perpetrator is a parent, carer, or immediate family member. This proportion is mirrored in our MIST program.

In the previous 12 months, 5% of the children supported through MIST have been 5 and under. We see the following impacts of CSA on children in the 0-5 age range:

- Child displaying sexualised behaviours and/or challenging behaviours
- Confusion for the child about the relationship with the abuser, because of heavy grooming
- Confusion and sadness for the child about the relationship with the abuser ending
- Challenges with forming appropriate relationships
- Trust issues
- Lack of boundaries, inappropriate touch and inappropriate connections with both family members and people they have just met
- Disconnection from their body and their body cues
- Developmental delays or children being "stuck" at the age the trauma occurred, resulting in being developmentally out of sync with their chronological age

More generally, Parkerville CYC takes a family systems approach to supporting children affected by CSA, including the provision of Family Therapists in MIST to further wrap holistic support around families as they navigate deeply traumatic circumstances – both the CSA itself, and the police, child protection and court systems. These systems often lack capacity to provide an individualised, child-safe, and child-centred approach, with families left to mould to the system, and participate in processes that are not developmentally appropriate. For example, expectations that a child will disclose their abuse to a stranger in a police setting, expectations that all children/families trust police, expectations that children will be assertive in the face of questioning by a defence lawyer, expectations that children will be strong and fearless when called a liar by a defence lawyer, expectations that a child will tell all of the details of abuse readily and not withhold details out of concern for those listening and what impact the full details might have on them, and expectations that a child, under stress, will be able to sit still and answer questions in both these settings.

Non-offending parents/caregivers often experience feelings of guilt and shame that are intensified by the real or perceived judgments of others and the stigma surrounding child sexual abuse, creating isolation, and making it difficult to process the impact of disclosure, and seek the necessary support to move forward. Families are often torn apart by CSA allegations, with extended families taking sides, children often not believed, and non-offending caregivers subject to intense supervision and scrutiny. Families often do not know how to parent a traumatised child (and their siblings), or where to turn for help. Families, who under normal circumstances can cope with dysfunctional relational patterns, are unable to contain the issues when CSA is disclosed and 'implode', resulting in an inability to create and sustain healing environments for their child. And, in addition, many of the families we support also have their own personal social issues, trauma histories and complexities, including previous interactions with police and child protection, positive and negative.

These histories and pressures can impact on families' capacity to participate in and navigate these systems, as well as successfully access supports and coping strategies, amid a context in which free, appropriate, trauma-informed services for families are lacking or subject to long wait lists. This point is particularly salient given the greater complexity of need with which families are presenting to MIST over 2022, including the increasing impact of systemic issues such as poverty and the need to link with emergency relief and food, and families requiring accommodation services. It is of note that 80% of the cases our MIST team works with are not opened to Child Protection, as there is a safe family

member, or members able to care for the child. These families are not prioritised in access to the free services, and can have multiple barriers such as poverty and locational disadvantage, that reduce their capacity to access ongoing supports – these are the families Parkerville fundraise to support, and for whom are Child Youth and Family Advocacy Centres are largely provided.

3. Focus issue: Children in Out of Home Care

Parkerville CYC is contracted to look after 126 children, cared for across 4 Tier 1 family group homes (FGH) (owned by the WA Department of Communities) in the Perth Metro area and 4 FGH in the Murchison, accommodating children usually aged 7-17 for up to 2 years; 5 FGHs owned by Parkerville CYC (usually sibling groups, without limits on length of care and from 0-17 years), and in foster care placements in Metro and the Murchison. Finally, Parkerville CYC runs an intensive residential program for young people aged 12-17 currently under the care of the Department of Communities (Belmont Youth Program); the home accommodates up to 5 children.

Parkerville has developed a new OOHC model, Our Way Home[2] – radically personalised shared care, where restoration is the end goal: reunification where safe and possible, or ongoing and stable shared care arrangements built on strong and trusting relationships between child, family, and carer.

[2] www.parkerville.org.au/what-we-do/out-of-home-care/our-way-home

Recommendations

17. Develop national guidance, with common terminology, about the specific development needs of under 5s with complex trauma; how their trauma and ACE histories impact on development during this crucial window; and how targeted and holistic intervention support can/should be accessed to mitigate impact of trauma and support positive developmental outcomes.
    a. This should be informed by a clear narrative of child outcomes at key life course points such as birth, entry to learning (age 2–3) and entry to school.
    b. This should be targeted towards all professionals working with this cohort (early and primary educators, healthcare, all child development services, etc.)
    c. This should also be inclusive of intensive family supports to enable them to address family functioning issues that impede creating safe healing contexts for children.
18. Prioritise access to early educational environments for children 5 and under in care:
    a. Pre-school early education access should not be case-by-case, at departmental discretion. All children 5 and under in care, whatever their placement type, or geographical location, should be guaranteed a minimum number of hours in early childhood education, per Standard 6 of the National Standards for out-of-home care.
    b. Individual learning plans should be part of care planning for all children coming into care, including children 5 and under, outlining how developmental and educational outcomes at key life course points will be met, with resourcing attached.
19. Develop a standardised framework for building cultural connection and family connection for under 5s, recognising the significance of maintaining and championing family and identity as part of early childhood development, given its lifelong impacts on wellbeing.
20. The impact of placement type on developmental outcomes for under-5s should be considered as a matter of priority, recognising that residential group homes are rarely the appropriate environment for young children. Maintaining sibling connection must be prioritised, but balanced against developmental needs for children 0-5.
21. Better resourced and more intensive leaving care support should be a national priority. Within this, Government must re-focus efforts on more intensive, holistic multi-agency support for care leavers who become pregnant, to support optimal outcomes for baby and parent, including determined efforts to ensure stable and long-term housing, and building parenting capacity to break the cycle of repeat, inter-generational child removal.

3.1 Younger children in Out-Of-Home Care: the case for intervening better, and earlier

There were 46,000 children in out-of-home care (OOHC) (defined as the provision of care arrangements outside the family home to children in need of protection and care) nationally at 30 June 2020. At 30 June 2021, there were 5,344 children and young people in OOHC in WA, more than half of whom (57.2%) were Aboriginal. This is a decrease from 5,498 children at 30 June 2020 (CCYP, 2022).

Children in OOHC have faced significant and complex issues, with pre-care histories often including abuse and neglect, and high levels of social disadvantage (such as living in highly disadvantaged

neighbourhoods, poverty and food insecurity, parental mental health, substance issues, or domestic violence) (Maclean, Taylor & O'Donnell, 2016). Young people who have been in care are at high risk of a range of poor outcomes, even compared to other children who have experienced adversities. This includes adverse outcomes in the areas of physical health, mental health, and education, with Aboriginal children with child protection involvement even more likely to experience disadvantage and poorer outcomes (Lima, Maclean and O'Donnell, 2018).

Children in OOHC have poorer physical, mental and developmental health compared to their peers, largely due to the adverse effects of neglect, abuse and trauma on neurodevelopmental and epigenetic and metabolic pathways, as well as the effects of disruption to attachment and family structures (RACP, 2019). They are also much more at risk of adult homelessness and lifelong disadvantage, including alcohol and drug misuse, having their own children taken into care, exclusion and antisocial behaviour, and negative overall wellbeing outcomes.

Child protection expenditure is by far the single largest area of late intervention expenditure in Australia (Teager, 2019). Early intervention is essential to shift the life trajectory and disrupt intergenerational cycles of disadvantage, reducing inequities in child health, well-being, and development, particularly for disadvantaged children (RACP, 2019). Routine, proactive, multi-disciplinary health screening to establish and address the complex effects of trauma on children in OOHC has been called for in the National Clinical Assessment Framework and the RACP's Statement on the Health of Children in OOHC, and the Royal Australian and New Zealand College of Psychiatrists have called for priority access to multidisciplinary developmental and mental health services for children in out-of-home care (RANZCP, 2021).

Despite this, evidence from Parkerville's OOHC practice demonstrates significant gaps in the provision of services to children in OOHC, creating both short-term and lasting impacts. Better intervention in the early years for children already in OOHC must become a priority, if we hope to better prevent escalation of need as children move though childhood, adolescence and into young adulthood.

3.1.1 Children 0-5 in Family Group Homes

Currently, 10% of the children in our care are 5 and under (most, but not all, are in foster care); 86% of those are Aboriginal. Our carers are dedicated, highly trained and highly experienced caring professionals, deeply invested in the wellbeing and development of the children in their care. It is rare for Parkerville to accept placements for children 0-5 in our FGHs; generally, this is done to keep a sibling group together and maintain normality and family connection as far as possible. However, we are seeing increasing system pressure to place children 0-5 in FGHs for lack of options elsewhere in the OOHC system. A child of any age in the care of the State must have a safe place to live. However, it must be acknowledged that FGHs are not, in general, the best place for under 5s. The 24-hour rostering model is qualitatively different to foster care, in which the same carer is with the child day in, day out, in a family home environment. Children under 5 have different developmental needs around attachment and carer consistency than older children.

Moreover, our older children in FGHs are at very different developmental stages, and are being supported by our carers and team leaders to manage and heal from the impact of profound and complex trauma. Older children exhibit trauma responses differently, in ways that may be confusing

and frightening for younger children. This is not an optimal environment within which to support earlier intervention for young children recovering from trauma.

3.1.2 Child development: complex, multiple, and intersecting need

The children that we support often require more than one child development service, alongside (or because of) their experiences of trauma. Many – if not most – of the children over 5 in our care have developmental, behavioural, mental and physical health needs, the effects of which may have been mitigated with faster diagnoses and implementation of treatment and intervention plans during the crucial earlier years of their development. Delays are often the result of extensive wait lists, a paucity of service provision, and/or system pressures and high caseloads for our children's case workers, meaning requests for referrals are slow to be actioned.

- ***Educational development*:** A significant majority of our children are educationally disadvantaged and not receiving the necessary support to engage with education and flourish at school. This starts in the early years, with our children not receiving timely referrals and interventions to address developmental delays and learning difficulties. Many of our children have multiple and intersecting needs, but system complexities create major challenges with getting diagnoses, to enable schools to access funding for appropriate classroom support. This starts before children start at school, where the opportunity for early identification and intervention lies. While we as an agency provide as much educational supports as we can outside out contracted boundaries, more must be done to address developmental need for children in OOHC at the systems level, and especially in these early years: not all providers are able to do what we can/choose to do.
- ***Mental health support:*** Many of our children require medication that can only be prescribed by psychiatrists, but with very few available and extensive wait lists (and our experience of reluctance from psychiatry to take on children in OOHC, often because of delays to receiving payment from the Department), it is extremely difficult to access this service.

3.1.3 Early Childhood Education

Evidence consistently demonstrates that high-quality early childhood education (ECE) can have significant impact on children's outcomes. A longitudinal UK study with nearly 3000 children found that children who attended preschool had better attainment in language, pre-reading, and early number concepts at age 5 than those who did not attend, after controlling for the influence of background characteristics, and projected longer-term outcomes including better science outcomes and socio-emotional outcomes at age 14 (Taggart et al., 2015). US longitudinal evidence has similarly shown the enduring benefits of high-quality ECE (Campbell et al., 2012).

Crucially, evidence suggests that high-quality ECE has a significant positive influence on mitigating the effect of disadvantage, equipping children with essential school readiness skills which impact on later-life outcomes. For children from lower socioeconomic backgrounds, high-quality preschool attendance enhanced educational outcomes and self-regulation skills at aged 11 and throughout adolescence (Taggart et al., 2015, Melhuish and Gardner, 2021). From the age of two, enriching childcare and early years education can reduce income-related gaps in early learning (Early Intervention Foundation, 2020).

We know that children in OOHC are some of the most disadvantaged; by this very fact, quality early educational opportunities should be of utmost priority. Indeed, this is reflected in the Government's own National Standards for Out-of-Home Care. Standard 6 states that, 'children and young people in care access and participate in education and early childhood services to maximise their educational outcomes.' This is to be measured by, 'the number and proportion of 3- and 4-year-old children who participate in quality early childhood education and child care services.'
Parkerville's OOHC services strive always to provide a nurturing, trauma-informed and safe environment for children: this is, nonetheless, a different (complementary) provision to an early childhood education setting. Children 5 and under in family group homes and other non-foster, non-kinship care placements who are eligible by default to ECE settings should be the rule, not the exception.

3.2 Pregnancy for young people leaving care

The Auditor General for WA found that Departmental leaving care support makes a positive difference to the young people who receive it, but about 65% of young people who are eligible for support do not get it early enough or at all, putting them at higher risk of being homeless, unemployed, missing out on education and training, and not getting the physical and mental health care they need (Auditor General WA, 2018). While some inroads are being made with legislation increasing the age for which services can be offered (via Homestretch), our experience is that many care leavers, especially those with complex needs, are not well prepared to leave care and start living independently. Under Standard 13, the National Standards for out-of-home care state that, 'one of the biggest challenges for all young people is to maintain independent living. Developing these skills and abilities enables them to take their place in society and this requires emotional support and practical assistance.' We do not see this for care leavers in practice: we are, for instance, seeing more Departmental referrals to our AYAS crisis accommodation service for young people leaving care, particularly those around 15/16 years old.

A high proportion of girls leaving care become pregnant within the first year. We have seen girls become pregnant very shortly after leaving care age is reached or when they self-select out of care; in some cases, within weeks or a few months. Young people are leaving care into a system ill-equipped to properly support them; this is magnified significantly if they become pregnant/a parent themselves. In some instances, these young people have made enormous personal progress in recovering from trauma and multiple disadvantage, and their children have remained in their care. However, we know from practice and research that the cycle is formidable, and that keeping care of their baby as a young care leaver is the exception, not the rule. Whilst in Parkerville care, we can provide holistic support, education and advocacy to young people around safe sex, healthy relationships, and sexual health, whilst ensuring a safe residential environment. A young person does not become less vulnerable upon leaving care; we should be continuing to work with young people intensively, particularly if they experience early pregnancy – knowing the systemic failures that contribute to greater risk of child removal and continued cycle. We hope that Homestretch will provide that overall option, however our experience is that not all young people engage, and it is here that we must focus our efforts.

Case Study
Redacted

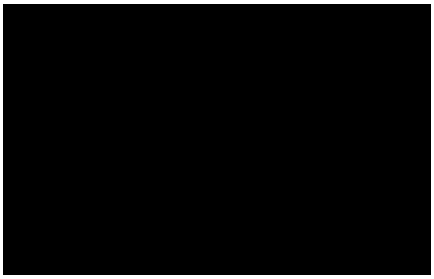
Summary

In our work supporting vulnerable children, young people, and families, we are continually awed by the resilience they display in managing the impacts of abuse, trauma and/or other, often overlapping, challenges. We know that child maltreatment can be reduced. We need to invest more, create systemic resource and measurement frameworks, and just do better.

There must be coherent, integrated support for families during pregnancy and the early years of life that works over the long term to reduce child poverty and inequality; that not only delivers high quality services directly to children, but also builds the confidence and capability of the people with whom children spend most of their time: that is, their families. This must be driven by strong national policy-making: a clear, strategic direction that drives change and creates the capacity at State and local levels to reflect on the way that national, State and local systems are functioning, to identify strengths and weaknesses, to build and learn from best practice and evidence.

This national agenda must be a crucial first step towards constructing a more integrated, coordinated system of family support, one which provides the right kind of support to more families who need it. Children and young people who have been highly disadvantaged by abuse, trauma, and other adverse childhood experiences, whose often complex and multiple needs repeatedly fail to be accommodated, require, and deserve, a system that supports them at the point of need to reach their full potential, despite the challenges they have faced.

Yours sincerely,



This submission was researched and written by [redacted] (contact details below) with assistance and contributions from Parkerville Children and Youth Care's talented teams in out of home care, youth, education, and therapeutic services. The generosity of the people we serve whose stories have been included must also be acknowledged, as they have brought to light the issues in meaningful and grounded ways.

Contact details

For further enquiries on this submission please contact:

[redacted]

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