Children affected by domestic and family violence

A review of domestic and family violence prevention, early intervention and response services

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Executive summary

This report sets out the findings of research into domestic and family violence (DFV) prevention, early intervention and response for children aged 0–8 years. The research was commissioned and funded by the NSW Department of Family and Community Services. It contributes to the development of the knowledge base on DFV prevention, early intervention and response strategies and the needs of children, and supports the implementation of aspects of the *National Plan to Reduce Violence Against Women and Their Children* (*National Plan*) and the NSW Government's *It Stops Here: Standing Together to end Domestic and Family Violence in NSW* (*It Stops Here*) strategy.

We acknowledge the need for holding perpetrators, not women and children, accountable for DFV, and the necessity of ongoing primary prevention of DFV addressing men, however as the key focus of this report is on prevention, early intervention and response strategies for children, it is beyond the scope of this report to engage in a detailed discussion of perpetrator programs or primary prevention activities targeting men. However, there is a further study, also commissioned by the Department of Family and Community Services, and undertaken by a team overseen by Professor Moira Carmody at the University of Western Sydney, that focuses on prevention targeting men and boys.

The research had two areas of focus:

- synthesising the literature on the impacts of DFV on children, and on the evidence for primary prevention and early intervention strategies for children aged 0–8 years; and
- identifying best practice approaches for primary prevention, early intervention and response for children aged 0–8, and identifying the extent to which these needs are met within existing DVF primary prevention, early intervention, and response approaches in Australia.

The research took place in conjunction with two other studies; a study examining DFV prevention initiatives for at-risk women, also conducted by AIFS, and a study that focused on primary prevention initiatives for men and boys. The latter study was conducted by a team at the University of Western Sydney led by Professor Moira Carmody.

The research

The study utilised a mixed methods approach to address the research areas, incorporating a literature review, stakeholder consultations and interviews, and an online Request for Information from services delivering DFV prevention, early intervention and/or response programs or from services undertaking activities that were concerned with prevention, early intervention and/or response. This strategy supported the collection of data from a variety of perspectives and allowed the research questions to be addressed using multiple sources of data.

The literature review involved three tasks: 1) a review of the research literature on the prevalence and impact of DFV on children aged 0–8 years; 2) an analysis of current national and international evidence, conceptual frameworks and good practice trends related to prevention, early intervention and response initiatives targeting children aged 0–8 years who are affected by DFV; and 3) a service mapping exercise to identify examples of prevention, early intervention and response programs and services focusing on children aged 0–8 years who are affected by DFV in NSW and other Australian states and territories.

The research team undertook consultations and interviews with a wide variety of stakeholders including policy-makers, service providers, practitioners, researchers and other professionals involved in the area of DFV prevention, early intervention and response for children. Following preliminary phone consultations, the research team conducted a series of more formal stakeholder consultations in the form of five half-day roundtables. Roundtables were held in Sydney, Melbourne and Brisbane.

The three stakeholder roundtables had 40 participants, representing 31 organisations. The research team also undertook an additional 5 interviews via phone with service providers who had been unable to attend one of the roundtable sessions. Drawing on the insights gleaned from the preliminary consultations, the purpose of the roundtables was to understand the practice experiences and perspectives of service providers and program managers, and to document key insights that would assist in formulating recommendations for enhanced or new approaches and exemplar models in NSW.

Drawing on the data collected during the various stakeholder consultations and also the literature review, the research team developed and circulated a Request for Information to service providers and program operators. The purpose of the Request for Information was to ascertain the range of initiatives and programs currently in operation in Australia, the nature of host organisations through which programs are delivered, the theoretical underpinnings of the program or service, the content and activities of the program or service, and the characteristics of clients using the program or service.

With both the stakeholder consultations and the Request for Information, service providers and program managers often indicated that the service or program had a focus on both young children and also at-risk groups and communities. For this reason, the data reported from the Request for Information and our consultation process may be reflected in the findings presented in both AIFS reports. Our Request for Information elicited responses from 104 services, which comprised of 69 full responses and a further 35 partially completed usable responses. The nature of responses and the nature of the services, themselves, meant it was difficult data to quantify. For example, most services indicated that they targeted/catered for more than one at-risk group in addition to targeting children and men, and most services conducted primary prevention activities in conjunction with crisis response, counselling and other DFV work. It was therefore not possible to delineate meaningfully, between service types or groups targeted and the data presented in this report is largely qualitative. Refer to Appendix 3 for further details about the Request for Information including the survey administered.

Main findings and policy implications

The need for a coherent philosophy and integrated responses

This research has demonstrated that a range of approaches and understandings of primary prevention, early intervention and response for children aged 0–8 exist among stakeholders and in the literature. Theoretical distinctions are often not maintained in practice with a wide overlap in the activities, services and programs undertaken, and ambiguity or uncertainty of the definitions of early intervention, primary prevention and response. In part this reflects the complexity of addressing DFV, and it also evidences a need for a clear framework to guide understanding and practice. A further issue that emerged strongly from the research, and has

been highlighted in other analyses of DFV responses, is the extent to which services across different sectors work independently and in isolation from each other. **The research suggests a significant need for better integration of services for children, including better communication and integration between family violence services and other systems including the child protection system, the state-based justice system, family support systems such as those that deliver maternal and child health services, and the education system.**

Over the last 20 years or so, there has been a move in many jurisdictions to an integrated policy and practice approach to complex social issues such as DFV. Throughout Australia, there are differing levels of integration of approaches to the issue of DFV and related service provision. Our study found that the DFV sector in NSW is characterised by a significant level of fracturing, and is located at the less coordinated end of the integration spectrum. One of the most important implications for practice that emerges from the research set out in this report is the need for a policy framework to support understanding and practice of DFV response, prevention and early intervention NSW. The report suggests that the governance infrastructure established to support *It Stops Here*, may provide a means of supporting the formulation of such a framework. **A clear and coherent policy framework to support understanding and practice of DFV response, prevention and early intervention NSW would better enable discrete service sectors to work towards common goals and ensure children's needs are met across the various sectors.**

Limited evidence for effective primary prevention strategies for children aged 0–8 years

As a field of knowledge and practice in Australia, DFV primary prevention is in its early phases. Australian developments in this area have been strongly influenced by international approaches, particularly the World Health Organisation public health model with its (socio-ecological) approach that focuses on preventing DFV before it occurs through the delivery of universal and targeted strategies across the life-span and in various community contexts. The under-pinning theory of causation in this framework is that DFV is a direct result of gender inequality, traditional gender roles and the interplay between factors at four levels of influence: individual, relationship/family, community and wider society. However, there is general agreement in the literature that there is a paucity of evidence for "what works" in primary prevention, and thus the socio-ecological model of primary prevention is largely theory-driven. As such, primary prevention strategies are generally based on what is known about perpetration. The literature around factors associated with perpetration strongly point to DFV as being linked with traditional/normative beliefs about gender, attitudes supportive of violence, and socio-economic factors such as low education, substance abuse, and a childhood history of trauma or DFV.

The rationale for primary prevention work with children is premised on the theory that attitudes to gender equality and violence are formed in early childhood. A key focus within public health frameworks has thus been on primary prevention education targeted at young people and children, as their attitudes are more readily influenced than adults.

However, our research found that there is relatively little evidence for the efficacy of programs for children under 8 years. School-based primary prevention programs that address the underlying cause of DFV are endorsed in the literature and recommended through international

and national policy frameworks. However, there are very few evaluated programs for children aged 8 years and under, as most evaluated programs are delivered to secondary school students. A key theme to emerge from both our literature review and stakeholder consultations has been the importance of delivering primary prevention programs to younger children, since attitudes to gender may have already been formed by the time they reach secondary school, or children may have already been exposed to DFV by this stage. A second theme to emerge was the importance of retaining a gendered analysis and understanding of DFV, and to work within a "whole of school approach" across the curriculum and in consultation with school communities. **There is a strong rationale for investment in the development, further research and evaluation of existing programs for primary school-aged children focusing on respectful relationships and the deconstruction of gender norms.**

Our consultations, Request for Information, and service mapping identified some promising school-based primary prevention programs for children in the 0–8 age group emerging. Many of these programs met the recommendations for good practice in school-based primary prevention: they were based in a whole of school approach, they were informed by a gendered theory of DFV, and they were aimed at creating lasting attitudinal change. **However, there is a need for further evaluation of primary school-based primary prevention programs. Furthermore, there is a need for an overarching primary prevention framework to articulate aims and approaches for these programs.**

Limited evidence for effective early intervention strategies for children aged 0–8 years

We found very little literature on effective practice in early intervention strategies for children in the 0–8 age group. Moreover, there was ambiguity in both the literature and practice understandings of what constituted early intervention. For example, many services characterised therapeutic responses to children as early intervention because the programs addressed the intergenerational transmission of DFV and/or other risk factors for DFV. Likewise, there was a view that given the prevalence of children exposed to DFV, school-based primary prevention may come after exposure and thus constitute early or tertiary intervention. In light of this, there was some international literature indicating that school-based early intervention, and even response models, may be appropriate given the frequency of children experiencing DFV.

In general, early intervention models were understood as models that targeted populations of children or pregnant women/new parents at higher risk of experiencing DFV. We identified a small number of targeted school-based primary prevention programs aimed at populations of children perceived to be at risk of exposure and/or future perpetration, however evidence of the efficacy of these programs is not yet clear. **There is a need for further research and evaluation of existing early intervention practice models for children aged 0–8 years. Our service mapping indicated that there is a service gap in early intervention programs aimed at pregnant women and early parenthood, though these groups are identified in the literature as being at higher risk of violence.**

Responding to children exposed to DFV

Recent statistics show that children are exposed to family violence to a significant extent in Australia. There is a considerable amount of international evidence showing that children

experience significant negative impacts over the short and longer term from such exposure; however, understanding of how this occurs and what factors mitigate against sustained adverse outcomes is developing. There is strong emphasis in the literature on the co-occurrence of witnessing DFV with other forms of child maltreatment, and the impacts of such exposure are thus thought to be difficult to determine. Key approaches to understanding the impact of DFV on children are based in theories of trauma and attachment, while other evidence focuses more generally on identifying the cognitive effects of DFV exposure and risks that may follow later in life, including future victimisation or perpetration of DFV or sexual violence. All of these perspectives contribute to the development of a better understanding of the impact of DFV on children, as does emerging research examining resilience. **This evidence reinforces the need for a multi-dimensional approach to understanding and responding to DFV.**

There is relatively little literature defining best practices responses to children exposed to DFV, and very few evaluated Australian programs. A key recommendation put forth in the literature in relation to children exposed to DFV, was that responses to children should be holistic and not be separated from responses to mothers (or non-perpetrating caregivers). There was a strong emphasis on the importance of therapeutic work that addresses the potentially damaged mother/child bond. **There is a need for further development and evaluation of programs that work therapeutically with the non-offending caregiver and child.**

The association between children's exposure to DFV and future perpetration of violence (the intergenerational transmission of violence) was much debated in the literature, mainly centring on whether the association is causal or the result of other interrelating factors such as maltreatment. Programs for children addressing the intergenerational transmission are recommended in the literature, though there is little evidence of their efficacy. Several of the therapeutic group programs identified in our service mapping aim to address this via pyscho-educational activities. However, while the literature emphasised the importance of addressing the future perpetration by or victimisation of children exposed to DFV, our stakeholders and interview participants were more predominately concerned with children's immediate to medium-term post-crisis needs and the ability of services to adequately meet these needs. The best practice strategy most commonly raised in stakeholder responses to children exposed to DFV, was the importance for services to be child-centred, tailored to the child's individual need and family context, and to work holistically with the child's mother/family, school and broader community. However, stakeholders identified that existing services were overburdened and unable to meet community demands for service. There was also some concern with allied health services, schools, and early childhood services being ill-equipped to respond to and identify children exposed to DFV. **There is broad need for more specialised children's DFV services (therapeutic and post-crisis response) and sector capacity building in the education and health professions.**

The large majority of services that we identified through our research, our stakeholder consultations, and our Request for Information were therapeutic programs which generally involved pyscho-educational activities aimed at addressing the intergenerational transmission of violence through various strategies designed to develop children's resilience, self-esteem and conflict-resolution skills. Many programs worked with both the non-offending parent and child through group work activities and individual counselling designed to address the potentially damaged parental bond. Furthermore, our service mapping revealed that most programs and services for children were not distinct from programs and services for women.

Summary

This research examines DFV prevention, early intervention and response strategies aimed at children aged 0–8 years. Research evidence is increasingly demonstrating the detrimental impact of DFV on young children. There is a need for further funding and support of post-crisis, therapeutic services for children that are child-centred and address the mother–child bond.

This report has found that there is a limited number of prevention and early intervention activities that focus on this age group, and there are significant gaps in the evidence regarding the effectiveness of prevention and early intervention activities aimed at the 0–8 age group. There is an emerging evidence base and strong rationale for supporting school-based primary prevention programs for younger children that address the underlying causes of DFV. Building this evidence base is crucial if we are to address the impact of DFV on young children and prevent them being subject to it. To do this, a coherent policy framework is needed that enables service providers, policy-makers and researchers to work collaboratively and effectively.