A review of the effectiveness of interventions for adult victims and children exposed to family violence

Prepared for the
Ministry of Social Development

16 July 2013

ALISON CHETWIN

Level 9, iCentre Building
50 Manners Street
PO Box 24181
Wellington 6142
TEL +64 4 473 3885
FAX +64 4 473 3884
www.litmus.co.nz

LITMUS

Contents

Preface

This report has been prepared for the Ministry of Social Development by Lisa Gregg from Litmus Limited and Alison Chetwin. The project has been guided and supported by Kathy Fielding from the Ministry of Social Development. Associate Professor Janet Fanslow of the School of Population Health at Auckland University reviewed the first draft.

Please contact Lisa Gregg (lisa@litmus.co.nz) or Alison Chetwin (alison.chetwin@clear.net.nz) if you have any questions about this report.

1. Executive Summary

1.1 Overview

This paper, produced for the Taskforce for Action on Violence within Families, examines the effectiveness of interventions that respond to victims of intimate partner violence and children exposed to this violence.

The paper considers what interventions might be most helpful in assisting women and children to become safer and in addressing the immediate and longer term consequences of experiencing violence. The interventions discussed represent only one segment of a large and complex system response to family violence. The system exists to hold offenders to account, to rehabilitate offenders, and to support and protect victims and children.

The many research reviews studied for this paper generally agree that several factors are common to effective interventions for both victims and children.

(a) Services need to be integrated, and be provided with multi-agency co-ordination or collaboration to be effective in addressing family violence and its impacts.

(b) Victims and children who have been exposed to intimate partner violence will have a variety of different needs. Therefore, we need to design response systems that are capable of addressing a variety of needs at different points in time and in different locations and sectors. Standardised interventions are less likely to engage their intended participant group, or to acknowledge participants' need to determine their own solutions. Interventions should also acknowledge and work with differences in culture, age, level of trauma, and co-occurring issues.

(c) It is important that both victims and children are offered longer term, on-going support.

(d) Effective interventions have:
- skilled, experienced and supported staff with a strong understanding of the dynamics of partner and other family violence
- a clear purpose and theoretical base
- strong linkages to other services which support victims and children.

The quality of the evidence

The quality of evidence for the interventions considered in this paper can be assessed across any combination of a range of dimensions, including the number of studies, size of studies and strength of design. Within the reviews, there are examples of robust outcome evaluations with comparative design and measurements over the longer term. However, many of the evaluations reviewed examine short-term outcomes only, involve small samples and have high attrition rates. Many of the NZ examples focus on how the intervention has been implemented and only a few measure outcomes.

The reviewers have chosen to qualitatively summarise the evidence for each intervention, rather than 'rate' the interventions according to the quality of evidence for their effectiveness. Rating may be misleading; partly because of the complexities of assessing quality, but also because quality of evidence is not the only factor to be considered in deciding which interventions should be funded. The interventions are seeking to achieve

outcomes to meet different needs. In reality, no single intervention will be sufficient and a variety of well integrated interventions is required. Moreover, the absence of evidence does not necessarily mean that an intervention is not effective, and may mean that more research is needed.

1.2 The effectiveness of integrated response

- There is strong evidence that well implemented integrated collaborative responses to victims, children and perpetrators result in better outcomes for families and reduced violence.

1.3 The effectiveness of interventions for victims

The interventions presented below flow from immediate (secondary) response through to longer term (tertiary) response

Refuge

- Based on victim self-reports, research has found that women are generally satisfied with their experience with refuge, or that it met their needs. There is some evidence of a positive effect on women's likelihood and ability to leave an abusive relationship. There is very limited information on the impact on re-victimisation (particularly in the long-term) but there are some indications that refuges may be effective at reducing re-victimisation.

Safe homes

- Findings from two evaluations of safe at home initiatives report positive outcomes for: provision of safe housing, reduced incidence of repeat abuse and injury, reduced homelessness, and improved feelings of safety for victims. There is insufficient information to assess the overall effectiveness of safe home interventions, but the inclusion of a NZ study increases relevancy of the findings.

Advocacy

- Studies of advocacy interventions have shown some promising findings with regard to reduced re-occurrence of physical and emotional abuse, improved quality of life, and reduced depression and psychological distress. However, on the whole there is insufficient evidence to confidently conclude that advocacy interventions are effective, and further research is needed.

Support groups

- There is some evidence that support groups may be effective at improving self-esteem and social support or connectedness, and reducing symptoms of psychological distress which are important outcomes for women's wellbeing and self-efficacy. However, the evidence is not strong due to limited studies, small samples, and high attrition rates.

Counselling and trauma-informed treatments

- Counselling and trauma-informed treatments may be effective at reducing depression and posttraumatic symptoms and increasing wellbeing for victims who have left abusive partners as well as those who are still at risk of violence. From the limited information available, there is some evidence that integrated or coordinated

approaches, and culturally-specific group and trauma-based treatment may have positive results for victims with co-occurring substance abuse issues.

1.4 The effectiveness of interventions with elder abuse

There is insufficient research into interventions for elder abuse to assess effectiveness of particular interventions. However, four common themes have been identified for addressing elder abuse: multidisciplinary approaches, diverse treatment options, a commitment to prevention, and local level responses.

1.5 The effectiveness of interventions for children

The interventions presented below flow from immediate (secondary) response through to longer term (tertiary) response.

Early intervention: integrated inter-agency response

- In countries where children exposed to intimate partner violence are referred to the statutory child protection agency, the statutory system has become overloaded and there has been little improvement to child safety.
- There is strong evidence that well implemented inter-agency responses result in better outcomes for families. Co-ordinated inter-agency response is thought to lead to a better understanding of risk to children and more flexibility in meeting their needs, although more research is needed to investigate these benefits.

Advocacy for children

- Advocacy has involved both casework and macro-level activities. A small number of evaluations show that advocacy has resulted in some early positive outcomes for children and mothers exposed to partner and other family violence, including in NZ. Attention to role clarity is important when implementing advocacy services.

Children in refuges

- When children live in a refuge an opportunity is presented to intervene early to respond to the effects of children's exposure to violence. The small amount of research shows that intervention at this stage can reduce children's overt behaviour problems at least in the short term, provided facilitators are highly skilled.

Integrated interventions for mothers and children

- There is strong evidence from a set of robust evaluations that interventions which support mothers and children together are more effective than interventions which support mothers and children separately. These interventions are particularly valuable in that they engage the parent in the child's perspective of the experience of violence and can strengthen a range of important outcomes such as attachment, children's ability to express emotions, and a reduction in problem behaviours.
- Although the longer term outcomes of an intervention for Māori children and their caregivers were not evaluated, important factors for engaging caregivers and children were having a kaupapa Māori basis and Māori facilitators with considerable experience in working with whānau.

Individual work with children

- Individual work which openly addresses the violence children have experienced is most suited to children who are more severely affected. A range of pre and post-test evaluations show improvements in children's behaviour problems, self-esteem, attitudes and knowledge of violence, anxiety, depression, aggression, social competence, knowledge of resources and safety, overall psychological well-being, and means of dealing with conflict.

Group work with children and young people

- Pre and post-test evaluations show that group work has had benefits particularly for adolescent boys who have been exposed to violence. It is important that groups cater for the range of individual needs within the group and that the programme does not reinforce stereotypes that boys' behaviour is problematic and lead to the boys' belief that they are responsible for the violence.

Parenting interventions

- An evaluation of a programme for fathers who have been perpetrators of family violence shows some improvement in their attitudes to their children, although take-up and attrition are problematic for these programmes. It is important to sequence interventions so that violent behaviours and safety are addressed first, and to emphasise that 'you can't be a caring dad while being a violent partner'.
- There is as yet insufficient evidence to determine whether early childhood home visitation reduces intimate partner violence.

Websites and helplines

- Websites and helplines are worth exploring as a way of reaching young people affected by violence, since many young people prefer to seek assistance this way, but little evaluation has been undertaken.

1.6 The effectiveness of family-centred interventions

There is limited information on the effectiveness of family interventions, which continue to be an area of contention. The evidence reviewed focused on family group meetings, restorative justice meetings, and couple counselling. The limited information available suggests there may be positive effects on reducing violence and child maltreatment and that caution is required.

Identifying who is suitable for family intervention is a key consideration to ensure victim safety. It is also important that supports are in place for victims and children before and after meetings. The literature currently suggests family interventions may be appropriate where victims want to remain with their partners, there is a low level of risk, the violence is less severe, and perpetrators take responsibility for their behaviour, all of which require careful and skilled assessment.

1.7 Conclusion

This review presents strong evidence that an integrated and collaborative system response is most effective in reducing victims' and children's exposure to intimate partner violence; and that integrated mother/child interventions are highly effective in assisting them to deal with the impacts of violence. It is clear that no single intervention will be sufficient. A variety of integrated and co-ordinated interventions are required to meet a variety of needs.

2. Introduction

2.1 Review purpose

The Centre for Social Research and Evaluation within the Ministry of Social Development (MSD) commissioned a review of evidence on effective interventions for intimate partner violence.

This paper presents a review of international and NZ research examining the effectiveness of interventions that respond to victims of intimate partner violence and children exposed to this violence. Its aim is to provide a shared and consistent understanding across the Taskforce for Action on Violence with Families (Taskforce) agencies in relation to 'what works' for victims and children exposed to intimate partner violence.

The paper describes effective interventions at a secondary and tertiary level, which are understood as:

- **Secondary intervention:** is a crisis immediate response to violence and aims to minimise harm once a violence incident has occurred, e.g. responses to provide safety, such as refuges and safe housing.
- **Tertiary intervention:** are longer-term responses and programmes in the wake of violence, which attempt to lessen trauma or reduce the long-term impacts associated with violence on victims including children exposed to violence.

The review covers interventions and programmes that are delivered by the non-government sector. It does not cover the effectiveness of statutory interventions (such as police and other front-line response), screening and risk assessment, family law response including protection orders and contact conditions relating to children, the criminal justice system response, child abuse interventions[1], or perpetrator programmes[2].

The focus on adult victims in this paper is restricted to women victims of intimate partner violence with an interest in two sub-groups: Māori victims and women with co-occurring substance abuse and mental health needs. The restriction to women victims is consistent with much of the literature reviewed. The evidence sourced commonly states that while men are victims of intimate partner violence, the impact and outcomes of intimate partner violence is different and has a greater effect on women (Sullivan, 2012; Ramsay et al, 2009). Effective interventions for male victims would require a specialised search of the literature.

2.2 Methodology

Within the topic scope, the searching process was defined by the following parameters:

- Published and grey material
- Documents published since 2005

[1] Other work in this area is underway under the Children's Action Plan.
[2] Perpetrator interventions are covered in the Department of Correction's report Community- based Domestic Violence Interventions (Slabber, 2012).

- Documents from NZ, Australia, Canada, United States of America (US), and United Kingdom (UK)
- Research-based evidence
- Existing literature and evidence reviews with a particular focus on systematic reviews and meta-analyses. Primary research studies were included where there were gaps in evidence or to include a NZ perspective. Studies on the effectiveness of interventions with Māori are included where information was found.

Initial documents were provided by MSD, including some unpublished material and internal documents. Multiple searches of databases were then undertaken by MSD library staff resulting in 53 articles that were considered relevant to the search and full text copies were accessed for further investigation. Many websites of Government organisations, Non-Government Organisations, and clearing houses were searched for additional reports and grey material (See Appendix 1).

Because of the limited time and resource available, this review is not a systematic review[3] of original sources. Care was taken to ensure that systematic reviews were included where they existed. While an extensive search was undertaken, we cannot guarantee that all literature relevant to the review was identified and included in this report.

This review has not intended to provide sufficient detail to guide the replication of any intervention. Rather it provides an overview and further sources to enable detailed study of interventions of interest.

Quality of the evidence

The quality of evidence for the interventions considered in this paper can be assessed across any combination of a range of dimensions, including the number of studies, size of studies and strength of design. The reviewers have chosen to qualitatively summarise the evidence for each intervention, rather than 'rate' the interventions according to the quality of evidence for their effectiveness. Rating may be misleading, partly because of the complexities of assessing quality, but also because quality of evidence is not the only factor to be considered in deciding which interventions should be funded.

The interventions are seeking to achieve different outcomes to meet different needs, including crisis response, immediate needs and longer term recovery needs. Moreover the absence of evidence does not necessarily mean that an intervention is not effective, and may mean that more research is needed. Process evaluation is useful in showing how the intervention is being implemented and how it is working, as a precursor to impact or outcome evaluation.

[3] Campbell Collaboration define a systematic review as a summary of the best available research on a specific question, using transparent procedures to find, evaluate and synthesize the results. Peer review is a key part of the process. (Campbell Collaboration, accessed 21 June 2013, from http://www.campbellcollaboration.org/what_is_a_systematic_review/)

3. Integrated inter-agency response

Interventions for victims of intimate partner violence and children who are exposed to that violence represent only one segment of a large and complex system response to family violence. The system exists to hold offenders to account, to rehabilitate offenders, and to support and protect victims and children. The entire system incorporates police and other front-line response, screening and risk assessment, family law response including protection orders and contact conditions relating to children, the criminal justice system response, as well as a variety of involvement from other sectors such as social services, health and education.

In a 2012 issues paper on building collaborations to eliminate family violence, the NZ Family Violence Clearinghouse (NZFVC) reported that co-ordinated collaborative system response results in better outcomes for victims and perpetrators of partner violence, better processes between agencies and reduced violence (Murphy & Fanslow, 2012).

Perpetrators who complete stopping violence programmes that are linked to an integrated system of services re-offend less frequently than those who complete stand-alone programmes (Shepherd, 2005; Muftic et al, 2007; Gondolf 2000 in Murphy & Fanslow, 2012). Also, where there are co-ordinated responses, victims engage with a wider variety of agencies for longer periods (Robinson et al, 2006; McDonald et al 2011 in Murphy & Fanslow, 2012).

The NZFVC identified a graduated continuum of intensity of approaches to inter-agency response.

- At the least formal level, networking focuses on informal communication with minimal decision making.
- At the second level, co-operation entails information sharing around a particular aim.
- At the third level, co-ordination entails more structured formal relationships and information sharing aimed to improve the response to clients.
- Finally, collaboration is more intense with multiple separate organisations committing to a common philosophy and formalised processes.

Some NZ examples which meet the NZFVC definition of collaborative inter-agency response are the Family Safety Teams and the Family Violence Interagency Response System (FVIARS). An evaluation of some Family Safety Teams 2005-6, found the teams experienced considerable challenges in developing relationships with collaborating agencies (Ministry of Justice Research and Evaluation Unit, 2008). However, Gregg's 2007 evaluation of the Hamilton Family Safety Team, which was not part of the Ministry of Justice evaluation, found that it was functioning as a genuine collaboration (Gregg, 2007). An evaluation of the FVIARS in 2003 found that a major strength had been improved relationships between agencies, but an outcome evaluation has not been undertaken (Centre for Social Research and Evaluation, 2003).

Success factors for integrated collaborative inter-agency response

Murphy and Fanslow (2012) have identified that to be successful, integrated collaborative inter-agency response needs:

- A strong national mandate and leadership for agencies to work collaboratively and a centralised source to feed information out to and from local networks that supports co-ordinated responses and minimises the risk of duplication.
- Members' written agreements on shared aims and objectives based on commonly agreed values-based philosophical framework. Roles, responsibilities and expectations need to be clearly defined and specified. Key components are transparent decision-making, participatory planning and continual monitoring.
- Investment in a dedicated co-ordinator role to ensure momentum is not lost and issues are resolved as they arise. Agencies need to support staff to invest time and resources into collaborative activities. Funding needs to support the networks to collaborate on primary prevention as well as intervention activities. Investment in communal training assists in building shared understanding and promotes trust and respect.
- Consistent monitoring and measuring of safety and accountability needs to occur in ways that support ongoing learning and which provide opportunities for inclusion of current best-practice of system-wide responses (Murphy & Fanslow, 2012).

4. Victims' needs

Before investigating the effectiveness of intervention types for victims, this section introduces victims' needs to provide a context within which interventions are developed and implemented. Two sub groups of interest are also introduced: Māori victims and women with co-occurring substance abuse needs.

4.1 Intimate partner violence in the population and responding to victims' needs

Intimate partner violence is physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners (Saltzman et al 1999, in Fanslow, 2005).

Intimate partner violence is a population problem. The Ministry of Justice national victimisation survey (NZ Crime and Safety Survey) reported that 5% of females in relationships were victims of a partner offence in 2008 (Ministry of Justice, 2010). In 2010, police recorded 53,316 family violence offences, and 25 family violence murders (which was 54% of all murders) (NZ Family Violence Clearinghouse, 2012 and 2012a). Health statistics show that in 2009, 646 women aged between 15-50 years were hospitalised following a family violence assault (NZ Family Violence Clearinghouse, 2012a).

Within the population of women who experience intimate partner violence there are a variety of needs, including crisis response, immediate needs, and/or longer-term recovery needs. Responding to victims' needs requires a system that is capable of addressing the variety of victims' needs, at different points in time and across different locations and sectors. The provision of well-connected quality services is imperative to achieve safety, minimise the impacts of victimisation, and prevent on-going victimisation or perpetration in later life.

To respond to victims' needs, clarity is required on where victims are likely to present for help, what their needs are, and how they can best be addressed. As women present to a variety of places for help a "no wrong door" model is required.

This creates a need for:

- all generalist services across multiple sectors to have embedded a basic understanding of the dynamics and consequences of family violence
- staff in social service agencies trained to be alert to any needs clients might have beyond the services provided by that particular agency, meaning that anyone experiencing violence can access services via seemingly unlikely sources
- specialised services that are capable of responding appropriately to victims of family violence
- specialised services that are capable of responding to severely traumatised individuals who need specialised care, such as victims with co-occurring substance abuse and/or mental health problems.

There is also a need for broader community outreach to ensure informal support networks are able to provide appropriate responses and support when victims seek help (Fanslow & Robinson, 2010). Data from the NZ Violence Against Women study found that 75% of

respondents had told someone about the violence they had experienced (Fanslow & Robinson, 2010). Victims most commonly told informal supports such as family and friends, rather than formal sources, such as police or health care providers. However, despite this help-seeking behaviour, more than 40% of women reported that no one helped them (Fanslow & Robinson, 2010).

4.2 Empowerment approaches

Interventions for victims of intimate partner violence are generally based on an empowerment approach, whereby women are provided with the information and support they need to make decisions for themselves. Women are informed about possible solutions and discuss options, rather than being prescribed solutions. This requires tailored services to meet the needs of the individual victims (Ramsay et al, 2009).

4.3 Social and emotional wellbeing framework

Sullivan (2012) introduces the 'Social and Emotional Wellbeing Promotion' conceptual framework to understand intimate partner violence interventions for victims. The framework describes factors that contribute to quality of life at an individual and family level, and also recognises the importance of community, social and societal context in influencing individual social and emotional wellbeing.

Based in this context, Sullivan states that programmes and interventions aim to reduce risk factors and enhance protective and promotive factors across seven predictors of wellbeing:

- self-efficacy
- hope
- social connectedness and positive relationship with others
- being safe
- good physical, emotional and spiritual health
- possessing adequate resources
- social, political and economic equity.

The first two factors are individual, intrapersonal factors, and those remaining are interpersonal and social factors operating at an interpersonal, community and social level.

It is important to see the outcomes, such as self-efficacy, self-esteem, and social connectedness, as being of high value in their own right and as important for the longer term recovery of women and children. For example, it is hard to go out and get a job without a reasonable level of self-esteem. Without a job, it is hard to achieve the economic security necessary to support safe housing arrangements.

4.4 Māori frameworks

Little research exists on the effectiveness of interventions for Māori. Given the continuing high rates of intimate partner violence among Māori, there are suggestions that current Pākehā systems and approaches are not working. Literature suggests that Kaupapa Māori

approaches are required whereby intimate partner violence is addressed from a Māori worldview and structured using Māori tikanga approaches. Definitions of intimate partner violence for Māori include the wider social, economic and cultural context and are framed within a Kaupapa Māori framework, grounded upon tikanga Māori (Te Puni Kōkiri, 2010; Te Puni Kōkiri, 2010a).

In considering programmes and responses to intimate partner violence for Māori, some key considerations include using models based on a Kaupapa Māori framework and having collective responses across whānau, hapū, iwi, and Māori communities to intervene and transform current experiences. This approach recognises that whakapapa and whānau are central to relationships (Te Puni Kōkiri, 2010).

4.5 Culturally appropriate interventions

In NZ there is little research into intimate partner violence with different cultural groups, migrant and refugee communities. The difficulty in quantifying intimate partner violence is heightened in migrant and refugee communities, who appear to be less likely than other NZ cultural groups to report intimate partner violence (Nam, Waldvogel, Stone & Levine, 2011). There are multiple explanations for the reluctance to report, including for example threats of increased violence or deportation, fear of the authorities, language difficulties, fear of losing children, cultural norms, and embarrassment and shame.

Research also shows that when women from migrant and refugee communities seek help from outside of their community, the help received is often not appropriate or what they were seeking (MacLeod & Shin, 1993 in Nam et al, 2011). Unless services are sensitive to the needs of particular cultures, their values often clash, for example:

- service emphasis on short-term dependency vs. women's value of self-sufficiency
- mainstream empowerment model vs. economic and community empowerment models
- individual counselling vs. community and family building
- individual rights vs. community rights
- services for the women vs. services that reach out to all family members
- written material vs. word of mouth communication
- emphasis on the crisis vs. emphasis on long-term healing and prevention
- secular approaches vs. spiritual approaches (MacLeod & Shin, 1993 in Nam et al, 2011).

The Ministry of Women's Affairs' (2010) literature review into culturally appropriate intimate partner violence interventions provides some generalisable insights from a largely international body of evidence. The review suggests mainstream services can better meet the needs of women from different cultural groups through:

- ensuring language accessibility in service provision (e.g. having bilingual staff or providing competent translators)
- providing same language support groups
- providing access to a broad range of services
- educating staff on appropriate multicultural approaches (Ministry of Women's Affairs, 2010).

4.6 The co-occurrence of victimisation and substance abuse

Substantial research exploring the connection between intimate partner violence and substance abuse demonstrates the two conditions are highly co-occurring. It is estimated that between 25% and 50% of women experiencing intimate partner violence also have substance abuse issues (Bennet & Bland, 2007; Gutierres & Van Puymbroeck, 2006 in Nicholas et al, 2012). The two problems are considered bi-directional in that either problem increases the risk of the other (Bennet & O'Brien, 2007; Nicholas et al, 2012).

The explanation for the co-occurrence of these issues and the relationship remains unclear. Intimate partner violence literature generally argues there is not a cause and effect relationship (Bennet & Bland, 2007; Fals-Stewart & Kennedy, 2005 in Mackness, 2008). It is clear however, that substance abuse and intimate partner violence together increase the likelihood and severity of harm and injury suffered (Braaf, 2012; Nicholas et al, 2012; Dutton, 1992 in Mackness, 2008).

The evidence of the co-occurrence and bi-directional relationship between intimate partner violence and substance abuse has led to co-ordinated and in some cases integrated models of service delivery to address both issues concurrently. This is a shift away from the previous reliance on parallel service delivery (Bennet & Bland, 2007; Bennet & O'Brien, 2007; Fowler & Faulkner, 2011; Macy & Goodbourn, 2012).

> ***"Recommended practices for addressing these co-occurring problems urge domestic violence agencies and substance abuse treatment services to screen, to assess, and to assist women with both issues in a co-ordinated way."*** (Macy & Goodbourn, 2012, p234)

Where information was found in the review, findings on the effectiveness of interventions with victims who have co-occurring needs are included in this paper.

5. Interventions for victims of Intimate partner violence

This section presents the evidence for a range of secondary and tertiary interventions for victims of intimate partner violence. It describes interventions and summarises the evidence on their effectiveness. Interventions included are: refuge, safe housing, advocacy, support groups, and counselling and trauma-based therapy. As stated earlier these interventions represent a segment of a wider system response that seeks to hold offenders to account and rehabilitate offenders, as well as to support and protect victims and children. While there is limited evidence on the impact and effectiveness of many of the interventions for victims, this does not mean that interventions are ineffective; simply there is insufficient evidence at this point in time to make a judgement on their effectiveness.

The focus is on secondary (immediate response to reported violence) and tertiary (long-term) interventions. The section does not cover screening and risk assessment, protection orders, statutory responses (such as police and other front-line response), or the criminal justice system response.

5.1 Refuge

Refuges[4] provide safe temporary accommodation for women and their children who are seeking safe housing away from an abusive partner. Refuges developed and spread across NZ after the first refuge was set up in 1973 in Christchurch, and the National Collective of Independent Women's Refuges was established in 1981. The first Māori women's refuge was established in 1987 in Hamilton.

> ***"The Women's Refuge movement (both here in New Zealand and internationally) started in a socio-political environment that denied the reality of family violence, and especially the existence of gender-based violence."*** (NZ Women's Refuge)

Refuges commonly offer additional services, such as support services, counselling, education and information, and safety planning. They also help facilitate access to healthcare, housing, legal assistance and protection orders.

In 2011/12, Women's Refuges affiliated to the National Collective of Independent Women's Refuges received 85,794 crisis calls. Over 8900 women and 7000 children accessed advocacy services in the community and 2273 women and 1424 children stayed in safe houses.[i]

As refuges offer a range of services it is difficult to measure the effectiveness of refuge as an intervention independent from the other services provided (Sullivan, 2012a; WHO, 2009). Studies generally focus on victims' experience and whether the refuge met victims' needs. Few evaluations assess the effectiveness of refuges at reducing re-occurrence of abuse, particularly in the long-term (Sullivan, 2012a; and WHO, 2009). The following section highlights the findings on the effectiveness of refuge for a range of outcomes measured. Findings on the effectiveness of advocacy services and counselling or trauma-based therapy interventions that are delivered in refuges, are included in the respective advocacy and therapy sections.

[4] Refuge is used in this report to refer to refuge and shelter. It is the commonly used term in New Zealand.

How effective are refuges?

Providing safety from abuse: From the limited evidence available, there are indications from victim self-reports that refuge may positively reduce the re-occurrence of physical violence. However, a minority of women report increased violence as a result of using a refuge (Bowker & Maurer, 1985; and Goodkin, Sullivan & Bybee, 2004 in Sullivan, 2012a).

Women leaving abusive partners: Refuge can have a positive impact on women's likelihood and ability to leave abusive relationships, particularly for those experiencing moderate to severe abuse (National Collective of Independent Women's Refuges 2000; Panchanadeswaran and McCloskey, 2007 in Sullivan, 2012a).

Meeting victims' needs: Overall victims are generally satisfied with their refuge experiences and find them helpful (Cannon and Sparks, 1989; and Fowler et al, 2001, and Lyon, Lane & Menard, 2008 in Sullivan, 2012a).

There is some NZ evidence that women with protection orders may be more likely to complete their refuge case plans, and be less likely to require refuge services in future, compared to those without protection orders (Crichton-Hill, Coker & Taylor, 2010).

Self-reported outcomes: Victims in a large-scale US study identified the following positive outcomes from their refuge experience:

- having more ways to plan for their safety
- knowing more community resources they could use
- feeling more hopeful
- feeling able to achieve goals (Lyon, Lane, & Menard, 2008 in Sullivan, 2012a).

Women in a large-scale Canadian study (Tutty, 2006 in Sullivan, 2012a) rated their experience in refuge to be particularly helpful for getting information about:

- coping with stress and anger
- improving self-esteem and self-care
- how to better protect yourself
- how to better help yourself
- how to recognise abuse
- child care and services for children.

No negative self-reported outcomes or consequences were reported in Sullivan's (2012a) review.

Impact on posttraumatic stress symptoms: Refuges may reduce trauma-related symptoms and depression and increase self-esteem between refuge entry and exit (Orava, McLeod & Sharpe, 1996 in Sullivan, 2012a).

Impact on victims' children: Self-reports from mothers have identified positive effects on children as a result of refuges, including that their children experience:

- increased support
- greater understanding of what had happened

- improved ability to express their feelings without using violence (Lyon, Lane & Menard, 2008 in Sullivan, 2012a).

Children's programmes in refuges are discussed in Section 7.

Effectiveness for Māori

A recent evaluation of Te Whakaruruhau Māori Women's Refuge provides useful commentary on a Māori designed, developed, and delivered approach[5]. It uses a holistic and whānau oriented approach as the basis of the intervention, rather than an individualised model traditionally used in refuges (Haar, 2011).

Initial feedback from staff and women who have used the service is positive, noting that experience with traditional refuges has not always worked for Māori victims. Some key features in the operation of Te Whakaruruhau Māori Women's Refuge include:

- A marae-based model where wāhine are welcomed, introduced, the purpose explained, and taken care of
- Collective and shared approach to food preparation
- Collective and shared approach to childcare
- Less structured and prescribed operations e.g. not having structured kai times
- Collective ownership over the refuge, where women and tamariki clients are stakeholders and partly own the refuge.

Suggested factors for success include:

- a focus on service delivery
- staff to client ratios aligned with those required for safe and quality service delivery
- training for staff
- locally designed programmes
- intensive education and support for women and tamariki.

Te Whakaruruhau Māori Women's Refuge have developed a ***Transitional and Wellbeing programme***, which goes beyond the provision of emergency accommodation to provide medium to long-term housing (Robins & Robertson, 2008). The programme is built of foundational values of whanaungatanga, manaakitanga and wairuatanga.

The implementation evaluation identifies some outcome measures that, while not tested, provide a starting point for considering what may be useful in measuring outcomes. The measures move from personal wellbeing in the short-term, to relational and community wellbeing in the medium and long-term (Robins & Robertson, 2008).

- Short-term personal change outcomes: to reflect healing towards long-term change, such as improved:
  - communication
  - self-confidence and self-esteem

[5] The evaluation does not provide findings on outcome measures.

- access to services
- personal growth.

- Medium-term relationship wellbeing outcomes: building skills and establishing a stable environment, such as:
  - employment or training
  - regaining care of children/tamariki
  - improved knowledge about intimate partner violence.
- Long-term community wellbeing outcomes: establishment of a sustainable life free from violence, such as:
  - interdependence (to do things for oneself through reciprocal relationships, not in isolation)
  - autonomy from the controlling tactics of the perpetrator.

Refuge for women with co-occurring issues

Some women with co-occurring substance abuse or mental health problems may not be able to be accommodated within mainstream refuge due to concerns about the severity of their needs, inability to provide sufficient support services, and the impact on other refuge residents (Macy & Goodbourn, 2012; Hager, 2010).

Anecdotal evidence from 39 NZ refuges reported approximately 178 women were denied access to 39 NZ refuges because of mental health or substance abuse problems over a period of six months (Hagar, 2010). Over the same period, 347 women were accepted into refuge who had mental health, alcohol or drug problems. A further 79 were moved out due to threats to other refuge users, or a lack of skill and expertise to work with them appropriately (Hager, 2010).

Hager's (2010) exploration into refuge examples in England, Scotland and Australia provides some insights into how services can be provided for women who find it difficult to access mainstream services due to co-occurring mental health, disability or substance abuse problems. Hager (2010) describes three models that can be considered for women with co-occurring needs:

- **Up skilling mainstream services with therapeutic skills**: enabling mainstream services to identify and provide basic therapy or referrals for generalised anxiety and depression.
- **Specialist services within mainstream services**: substance abuse and mental health support workers working with refuges and clinical services to support women to engage with both services simultaneously. This approach requires increased staff and the availability of specialist staff.
- **Specialist long-term refuge services**: refuges tailored for addressing complex and co-occurring needs and enabling a period of stability before treatment starts. Specialist facilities and staff are required, with a high ratio of staff to women, to treat intimate partner violence and substance abuse or mental health issues at the same time.

In summary, based on victim self-reports research has found that women are generally satisfied with their experience with refuge and that it met their needs. There is some evidence of a positive effect on women's likelihood and ability to leave an abusive relationship. There is very limited information on the impact on re-victimisation, particularly in the long-term, but there are some indications that refuges may be effective at reducing re-victimisation.

While some studies include pre and post measures, studies of refuge effectiveness are limited in that they do not include random control trials and rely on victim self-reports. Because refuges offer a range of interventions it is also difficult to distinguish whether it is the other interventions or the refuge itself that is having an effect.

5.2 Safe homes

The NZ Safe@home intervention is based on UK Sanctuary Schemes. It involves improving the safety of victims' homes to allow victims and their children to remain there. The intervention is for victims at high risk of intimate partner violence, who want to stay in their own home, and who do not want the perpetrator in their homes.

The intervention involves a collaborative approach across agencies. The installation of security measures is dependent on the degree of risk and the type and condition of the property. In NZ, the services may include locks, stronger doors, secure windows, personal alarms, escape plans, phones, security lights, and offers of police drive-bys.

The intent of the intervention is to reduce victims' fear of violence, to minimise disruption from having to move homes or into refuge accommodation, and increase stability by allowing victims to stay in their homes and the community they know (Martin & Levine, 2010). In the UK, these interventions are also considered to be a way of reducing homelessness (Jones et al, 2010).The NZ intervention is currently funded by the Ministry of Justice and further evaluation of the initiative is planned.

How effective are safe home interventions?

Evaluations of the UK initiative by Jones et al (2010) and the NZ Safe@home intervention (Martin & Levine, 2010) have shown the following outcomes:

- safe housing for those at high risk of repeat intimate partner violence
- reduced disruption and providing more housing choice
- reduced incidence of repeat physical abuse, and fewer injuries
- reduced homelessness
- reduced damage to homes
- improved self-reports of feelings of safety
- improved self-assessed wellbeing (e.g. reducing anxiety, and improving sleeping, confidence, stability and concentration).

Wider benefits identified from the NZ evaluation include:

- reduced relocation grants and advances from Work and Income NZ
- fewer fire starts and associated call-outs

- higher victim trust in agencies (including police)
- improved communication and understanding between agencies
- better agency access to high-need clients.

While the findings are generally positive, there is some evidence from the UK evaluation that victims continue to feel unsafe when outside of the home, or when leaving their homes and a minority of respondents in the UK study also reported continuing to feel unsafe in their homes after the scheme was implemented. There are also some indications in the UK study that insufficient support services were in place in some areas where the intervention was delivered. This was due to limited capacity of specialist services to match the increased demand for their services, resulting in the use of waiting lists for victims to access support services (Jones et al, 2010).

Success factors for safe home interventions

Based on the UK intervention, the following factors have been identified as good practice for delivering safe home interventions (Jones et al, 2010).

- **Collaboration**: all agencies involved in the development of the initiative, with the right agency membership and leadership, and good communication between agencies.
- **Co-ordinator role**: having specialist knowledge of intimate partner violence, and with overall responsibility for bringing together the agencies.
- **Holistic package of support:** safe homes as one element in a package of support.
- **Needs assessment**: including a personal safety plan, assessment for children's needs, and referral to agencies.
- **Risk assessment**: to identify those most at risk and determine what security measures are installed.
- **Timely delivery of security measures**: prior to the option of providing interim safety measures.

In summary, two evaluations of safe at home initiatives report positive outcomes for victims who are at high risk of intimate partner violence, who want to stay in their own home, and who do not want the perpetrator in their homes. Safe at home interventions have been found to be effective at: providing safe housing, reducing the incidence of repeat abuse and injury, reducing homelessness, and improving feelings of safety for victims.

Findings are based on two primary studies only, and these were not experimental designs. Therefore it is unknown to what extent the intervention caused the observed effects, or what victims' outcomes might have been without the intervention, or with an alternative intervention. The inclusion of an evaluation of a NZ intervention increased the relevancy of the findings.

5.3 Advocacy

Advocacy involves actively working with victims of intimate partner violence (and on their behalf) to change problematic policies, practices and conditions. Advocates may also work across systems or sectors, or within a specific area such as housing, or legal systems with the goal of fixing recurring issues and problems (Sullivan, 2012b).

Interventions with victims may be brief (e.g. a single meeting), or they may be intensive, long-term interventions delivered as a standalone service or incorporated into other service delivery. The aim of advocacy interventions is to empower victims and link them to community services and other needed supports (Ramsay et al, 2009).

Ramsay et al (2009) define advocacy to include:

- providing legal, housing and financial advice
- facilitating access to and use of community resources such as refuges, emergency housing and psychological interventions
- providing safety planning advice.

How effective are advocacy interventions?

There are limited scientific studies assessing the impact and effectiveness of advocacy interventions on victims of intimate partner violence (Sullivan 2012b). Ramsay et al's (2009) systematic review of 10 random control trials found that there may be some improved outcomes from brief or intensive advocacy with abused women however, there is insufficient evidence to prove or disprove that advocacy interventions lead to a reduction or cessation in abuse or an improvement in psycho-social health outcomes for women who are victims of intimate partner violence. This is because there are insufficient studies with experimental designs that measure the same outcomes with the same measuring scales, and over a similar (and reasonable) time period, to draw strong conclusions (Ramsay et al, 2009).

This does not mean that advocacy interventions are ineffective, simply there is insufficient evidence at this point in time to make a judgement on their effectiveness.

> ***"Brief or intensive advocacy to abused women may improve a wide range of outcomes but these are still uncertain."*** (Ramsay et al, 2009, p47).

Physical abuse: There is insufficient evidence to determine the impact of advocacy on the re-occurrence of physical abuse. Some positive findings were identified:

- brief advocacy with pregnant women attending antenatal care reduced minor abuse
- intensive advocacy with women exiting refuges reduced physical violence, including severe violence in the short-term and medium-term
- intensive legal advocacy for women obtaining protection orders reduced physical violence (Ramsay et al, 2009; Sullivan, 2010b; Stover, Meadows & Kaufman, 2009).

Emotional abuse: Little evidence was found on the effectiveness of brief or intensive advocacy on reducing emotional abuse. While findings are not strong, there is some evidence of a positive effect for:

- brief advocacy with pregnant women attending antenatal care significantly reducing emotional abuse
- intensive legal advocacy for women obtaining protection orders reducing psychological abuse (Ramsay et al, 2009; Sullivan, 2012b; Stover et al, 2009).

Sexual abuse: No evidence of effectiveness of advocacy was found for reducing sexual abuse (Ramsay et al, 2009).

Quality of life: Mixed results were found with some evidence of improvements from intensive advocacy interventions with women exiting refuges or receiving community support, including up to three years after intervention (Ramsay et al, 2009). One-off advocacy sessions with pregnant women showed significant improvement in some measures of quality of life (e.g. physical functioning), but no effectiveness in other measures including general health, vitality, social functioning, and mental health (Tiwari, 2005).

Depression: There is inconsistent evidence of the effect of intensive advocacy interventions at reducing victims' experience of depression in the short-term. There is some evidence that advocacy results in reduced depression in women exiting refuges at a 12 month follow-up period. However a meta-analysis of this data found no effect. There was also no evidence of effectiveness at 2 years follow up. There is however, some evidence that brief advocacy with pregnant women attending antenatal care may be effective at reducing depression (Ramsay et al, 2009).

Anxiety and distress: There is some evidence of reduced psychological distress as a result of brief advocacy when delivered in a hospital accident and emergency setting.

Secondary outcomes: Ramsay et al (2009) identify secondary outcomes (psychosocial health outcomes, safety behaviours and accessing resources) that are measured in some studies on advocacy interventions. Findings from these studies are highlighted in the table below.

Secondary outcomes (Ramsay et al, 2009)

Outcomes measured	Evidence of effectiveness
Psychosocial health outcomes	
▪ Posttraumatic stress disorder	No
▪ Perceived stress	Yes, when delivered in hospital emergency setting
▪ Self-efficacy	Yes
▪ Self-esteem	Unclear
▪ Social support	Yes
▪ Independence from perpetrator	No
▪ Emotional attachment to the perpetrator	Some evidence for effectiveness in the long-term, but no short-term change
Safety behaviours	Yes, for women seeking protection orders or who currently fear for their safety
Accessing resources	Mixed findings. Some findings of a positive impact on accessing resources in the medium-term

In summary, A review of 10 random control studies of advocacy interventions has shown some promising indications for advocacy interventions with regard to reduced re-occurrence of physical and emotional abuse, improved quality of life, and reduced depression and psychological distress. However, on the whole, there is insufficient evidence to prove advocacy interventions are effective. This is because of a lack of experimentally designed studies that include the same outcomes (and measures) to draw strong conclusions.

5.4 Support Groups

Support groups are designed to provide emotional, psychological, educational, and practical support to people who share a common problem. They can be facilitated by peers, professionals or para-professionals.

Support groups for victims of intimate partner violence are intended to counter some of the negative results of abuse. Through a process of education, sharing experiences and providing mutual help and support, the groups are intended to increase social support, reduce stress and depression, and increase self-efficacy and self-esteem (Macy et al, 2009; Sullivan, 2012c).

Research exists into the effectiveness of support groups with a variety of populations. Evidence on the effectiveness of support groups for intimate partner violence victims, however, is limited.

How effective are support groups?

There is some evidence[6] to suggest support groups for victims are effective at:

- reducing symptoms of psychological distress (Constantino, Kim & Craen, 2005)
- improving feelings of social support (Constantino, Kim & Craen, 2005)
- reducing need for healthcare services (Constantino, Kim & Craen, 2005).
- improving self-esteem and sense of belonging (Fry & Barker 2002 and Tutty et al, 1996 in Sullivan, 2012c)
- improving coping abilities (Tutty et al, 1996 in Sullivan, 2012c)
- improving self-efficacy (Fry & Barker, 2002 in Sullivan, 2012c)

One study looking specifically at the efficacy of psycho-educational support groups for older victims of intimate partner violence found no significant differences for a range of behaviour traits, including depression, guilt, and self-esteem, when compared to the control group (Brownell & Heiser, 2006). Suggested explanations for a finding of no change include methodological issues (small sample, measures not sensitive enough to identify changes), participants receiving social support services prior to the start of the study, and that group sessions may need to be longer to create an effect (Brownell & Heiser, 2006).The suggestion of methodological issues seems particularly relevant given some qualitative feedback from participants suggesting a positive experience.

[6] Only Constantino, Kim and Craen's (2005) study is based on a random control trial.

Qualitative feedback from participants (including elder participants) suggests they found support groups a desirable source of assistance, that the group helped them to connect with other women, increased self-esteem, reduced feelings of isolation, and made them feel more confident and empowered (Sullivan, 2012c; Brownell & Heiser, 2006).

Attrition rates for support groups suggest they may not be suitable (or they are not suitably delivered) for all victims. Further research is needed to understand for whom support groups are useful, under what circumstances, and with what group characteristics.

In summary, there is some evidence that support groups may be effective at improving self-esteem and social support or connectedness, and reducing symptoms of psychological distress, which are important outcomes as they relate to other outcomes such as improved parenting and self-efficacy.

There are methodological limitations in the evidence base for support groups. Most notably there is a small selection of studies, small sample sizes, and high or unreported attrition rates.

5.5 Counselling and trauma-based therapy

The intent of counselling services is to increase wellbeing and alleviate distress, such as depression, anxiety, posttraumatic stress, guilt and shame (Sullivan, 2012). Many intimate partner violence services offer counselling services, which may incorporate a variety of therapeutic approaches, including trauma-based approaches.

Trauma-based therapy (such as cognitive therapy and cognitive behaviour therapy) was traditionally developed for a single event that occurred in the past. Such treatments have been modified for treating victims of intimate partner violence to accommodate the unique situation where victims may experience ongoing abuse or threat of abuse, and may have suffered multiple types of trauma.

How effective is counselling?

Sullivan (2012) identified three studies on different types of counselling services for victims of intimate partner violence. Findings show that grief counselling, emotional-based counselling and goal-oriented therapy have all produced findings of increased self-efficacy and self-esteem. Both emotional-based counselling and goal-oriented therapy also have resulted in reduced depression, increased family bonding, decreased family conflict (goal-oriented therapy), and increased social support (emotional-based counselling) (Sullivan, 2012).

How effective are trauma-based therapies?

Reviews of trauma-based therapy for victims of intimate partner violence suggest some positive results for reducing depression and posttraumatic stress symptoms, and increasing wellbeing and self-esteem (Warshaw, Sullivan & Rivera, 2013; Casteel & Sadowski, 2009).

Two studies (Kubany et al, 2003 and Kubany et al, 2004, in Warshaw et al, 2013) showed the following positive results for victims who were out of abusive relationships:

- improved posttraumatic stress
- reduced depression

- significantly reduced guilt
- increased self-esteem.

Warshaw et al's review (2013) included three studies of trauma-based therapies for women who are still at risk of intimate partner violence. Two of these studies delivered therapy to victims in refuge. Results across these studies showed:

- reduced depression severity and anxiety
- reduced posttraumatic stress symptoms
- increased social support
- increased empowerment
- reduced likelihood of subsequent abuse (found in one study, at six months after leaving the refuge).

Issues with attrition rates are emphasised when therapy is delivered in refuge. There are reports of high engagement and satisfaction with therapy while victims are at refuge (Crespo & Arinero, 2012 in Warshaw et al, 2013). However, attrition rates are high as women may not complete the therapy when they leave refuge. As a result there are suggestions for treatment to continue to be delivered to those who exit refuge to enable programme completion (Crespo & Arinero, 2012 in Warshaw et al, 2013).

Most of the trauma-based therapies identified in Warshaw et al's (2013) review involved modified cognitive behavioural therapy. This often involved standard behavioural and cognitive modules with modifications to address trauma-related guilt, histories of other traumas, likelihood of ongoing contact with the abuser for parenting arrangements and risk of subsequent victimisation. Therapy for victims still at risk of violence prioritised safety needs and empowerment, before introducing cognitive and behavioural modules.

How effective are trauma-informed responses for victims with co-occurring issues?

There is insufficient evidence at the current time to draw conclusions on effective treatments for victims with co-occurring substance abuse issues. There are few studies that assess coordinated or integrated trauma-informed interventions that address substance abuse and intimate partner violence. Those that do tend to focus on substance abuse and mental health outcomes. There is also no assessment comparing effectiveness of coordinated and integrated models (Fowler & Faulkner, 2011). Findings presented here are from Fowler and Faulkner's (2011) meta-analysis of the limited studies available. Eleven studies were included in their review, which included nine studies from the US Women Co-occurring Disorders and Violence Study (WCDVS studies)[7].

There is some evidence that co-ordinated or integrated approaches may produce positive results for women with co-occurring intimate partner violence and substance abuse issues (Cocozza, 2005; Bennett & O'Brien, 2007 in Fowler & Faulkner, 2011). The specific services provided varied. Using a pre-measure and post-test at four to six months after intervention, this study showed:

- a significant decrease in self-reported drug and alcohol use

[7] The WCDVS studies were of women who had experienced abuse or sexual trauma generally, with between 44-61% of the samples being victims of intimate partner violence (Fowler & Faulkner, 2011).

- increased domestic violence self-efficacy and ability to manage abuse-related difficulties.

There are, however, some findings showing increased vulnerability to and experience of abuse[8]. Further research is required to understand this increased level of risk. Possible explanations include victims' increased awareness of their risk from sobriety or increased violence from the perpetrator as a response to victims' sobriety (Bennett & O'Brien, 2007).

Using four different group and trauma-based interventions, findings from the WCDVS studies also show support for integrated services for victims. They found that services were effective at improving posttraumatic stress and drug and alcohol severity (Fowler & Faulkner, 2011; Cocozza et al, 2005). However, there was substantial variation in effectiveness across sites delivering the services. In assessing different programme characteristics, Cocozza et al (2005) found that sites providing more integrated counselling services had more favourable results.

A culturally-specific group-based trauma treatment programme was designed to prevent substance relapse and promote relationship safety for Black and Latina victims of intimate partner violence who were currently receiving treatment for substance abuse (Gilbert et al, 2006 in Fowler & Faulkner, 2011). Compared to a control group, this treatment programme resulted in:

- decrease in self-reported "minor" intimate partner violence
- reduced drug use and binge drinking
- significant improvements in depression
- significant improvement in some traumatic stress measures (avoidance), but not others (hyperarousal or re-experiencing symptoms).

Another culturally-specific intervention, identified in Warshaw et al's review (2013) of trauma interventions, was for low-income African American victims of intimate partner violence who are also suicidal (Kaslow, et al., 2010 in Warshaw et al, 2013). The program focused on support networks and communities as well as intrapersonal therapy. When compared to a control, modest findings were reported for the effectiveness of this intervention:

- improved depression and psychological distress for both groups, with a steeper decrease in symptoms over the treatment period for the intervention group
- improvements in depressive symptoms were maintained at 12 month follow up for the intervention group
- ongoing intimate partner violence was less likely to be associated with suicidality and suicidal ideation scores remained relatively low for the intervention group (Kaslow et al, 2010 in Warshaw et al, 2013).

Fowler and Faulkner's (2011) meta-review found trauma-based interventions for victims with co-occurring substance abuse issues are most effective when:

- women have recent experiences of intimate partner violence
- women are younger

[8] This was measured using the Women's Experience of Battering scale, which quantifies the experience of battering rather than the frequency of individual violent events.

- interventions are culturally relevant to the population they are delivered to.

Components of effective therapies

The research on trauma-based therapies includes different therapy designs (e.g. group or individual sessions, programme content, number and frequency of sessions and treatment settings). There is insufficient consistency across studies to explore what features are most effective.

Drawing across the limited information currently available, Warshaw et al (2013) suggest that helpful components of trauma-based therapies may include:

- Psycho-education about causes and consequences of intimate partner violence and its effects
- Attention to on-going safety
- Cognitive and emotional skill development to address trauma-related symptoms and other life-long goals
- Focus on the survivors' strengths and cultural strengths.

Findings from the US Women Co-occurring Disorders and Violence Study also recommend:

- Integrated counselling services (Cocozza et al, 2005)
- Integrating women into every level of the process as consumers, survivors, and recovering women
- Individual and team-based case management with small case-loads (Bennet & Bland, 2008).

In summary, counselling and trauma-based therapy may be effective at reducing depression and posttraumatic symptoms and increasing self-esteem and wellbeing. Positive results have been shown for victims who have left abusive partners as well as those who are still at risk of violence.

From the limited information available, there is some evidence that integrated or coordinated approaches, and culturally-specific group and trauma-based treatment may have positive results for victims with co-occurring substance abuse issues.

Evidence in this area is largely based on control trials, comparison groups, and pre/post-tests. There are some methodological problems with small sample sizes, limited follow-up periods to assess impact, and issues with retention rates. Further research is needed into the differences between those who complete treatment and those who do not, to understand victims' perspective of the treatment they received.

6. Interventions with older people

This section considers interventions for older people who are victims of violence, and includes considerations for effective approaches with older Māori victims.

6.1 Describing elder abuse

There are multiple definitions of elder abuse. In NZ both Fallon (2006) and Fanslow (2005) include reference to the definition from the World Health Organisation, which defines elder abuse as follows.

> ***"Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."*** (World Health Organisation, 2002, p3)

Aged Concern NZ identify four main types of elder abuse: physical abuse (pain, injury, or use of force), psychological/ emotional abuse (behaviours causing anguish, stress or fear), financial abuse (e.g. illegal or improper exploitation and use of funds/ resources), and sexual abuse (e.g. threats, forced engagement in sexual activity or exploitation of the inability to consent to sexual activity) (Age Concern NZ, in Peri, Fanslow, Hand & Parsons, 2008).

Elder abuse and neglect is usually committed by a person known to the victim, with whom they have a relationship implying trust, and on whom the victim often relies for basic needs (Age Concern NZ, in Peri et al, 2008).

In NZ there are no known large-scale measures of the extent of elder abuse (Fanslow, 2005). International estimates (Australia, UK, Canada and US) suggest between three and 10 percent of older persons are abused or neglected (Fanslow, 2005; Fallon, 2006). As with intimate partner violence and child abuse, elder abuse is often hidden and there is considerable under reporting (Glasgow & Fanslow, 2006; Nam et al, 2011).

A NZ report identifies risk and protective factors for elder abuse and neglect occurring or recurring (Peri et al, 2008). Protective factors include supportive families and social connectedness. Risk factors include isolation, physical challenges from ageing, cost of living, and unavailability of care. In residential care settings risk factors were about staffing issues (training, funding, staff-to-resident ratios and organisational culture). Strong themes also emerged in the report about the undervaluing of older people in society as a whole. Māori perspectives on elder abuse in NZ were described in terms of the stresses and pressures of life on the whānau (Peri et al, 2008).

Approaches

There is a dearth of research into interventions for elder abuse (Fanslow, 2005; Fallon, 2006; Ploeg, Hutchinson, MacMillan & Bolan, 2013). Drawing on the limited information available, distinct themes have been identified for addressing elder abuse:

1. **A commitment to prevention**: with a particular focus on education
2. **A multi-disciplinary approach**: focused on various strands of intervention and cross-agency collaboration

3. **Diverse treatment options**: which respond to differing needs, environments, co-occurring problems, and whether intimate partner violence is a long standing problem
4. **Local responses**: which acknowledge differing population needs and capabilities to respond (Keys 2003, in Fallon 2006).

Cultural approaches

It is important to incorporate different cultural perceptions into what constitutes elder abuse, and how best to prevent, identify and intervene (Fallon, 2006; Glasgow & Fanslow 2006). Culturally determined variation may exist in the motivation for mistreatment, and therefore different culturally appropriate responses may be required for interventions (Fallon, 2006; Nam et al, 2011).

6.2 How effective are interventions with older people?

A systematic review of eight studies available on effective interventions for elder abuse concluded there is insufficient evidence to support or reject any particular intervention types (Ploeg et al, 2013).

Reoccurrence of abuse: Two of the interventions reviewed showed negative results with increased rates of abuse: volunteer advocacy to victims using the criminal justice system, and police and intimate partner violence counsellors delivering education and home visits to households who reported elder abuse to police. Ploeg et al (2013) cautions that methodological issues with the studies may explain the results, rather than the treatments being harmful (e.g. issues with data entry quality, poor retention of participants in the intervention groups, participants not receiving the intervention, and problems with adherence to protocols for delivery).

Relocation of home: There are high rates of relocation (moving to live in a different home, including into nursing home facilities) for older victims of abuse. Relocation can be a positive outcome in relation to reduced risk of violence. However, there are negative implications such as unfamiliar surroundings, a possible reduction in autonomy, and disruption of social relationships (Ploeg et al, 2013).

Social and psychosocial outcomes: Most studies have found no significant improvements in outcomes across a range of measures (depression, psychological wellbeing and self-esteem). There is some evidence for reduced social isolation from the provision of assistance, support and advocacy for elder abuse victims in the criminal justice system (Ploeg et al, 2013).

Suggested approaches for effective interventions with Māori

Services for older Māori are best conceptualised in a whānau ora, holistic, culture-specific model, which emphases collaborative decision-making (Glasgow and Fanslow, 2006). Having an individual meeting with the older person first is important for identifying issues that cannot be discussed in front of the whānau and to determine who the older person wishes to have involved (Glasgow and Fanslow, 2006).

The delivery of a culturally safe and competent service that responds to older Māori should be underpinned by the following principles:

- safety and protection are paramount
- a Māori-friendly environment
- culturally safe and competent interaction
- collaborative community approach (Glasgow and Fanslow, 2006).

In summary, four common themes have been identified as important for addressing elder abuse: multidisciplinary approaches, diverse treatment options, a commitment to prevention, and local level responses.

There is a substantial lack of evidence on effective interventions for elder abuse. What is provided here are current findings, but the limited number and quality of the studies means they do not provide evidence for best practice. Further mixed methods research is needed to develop an understanding of what works, for whom, and under what environments.

7. Interventions for children exposed to intimate partner violence and other family violence

This section examines the evidence for effectiveness of interventions for children who are exposed to intimate partner or other family violence. It draws on existing reviews of the extensive research in this area from NZ, Australia, the UK, Canada and the US.

The focus moves from secondary interventions (which immediately follow reported violence and seek to restore safety) to tertiary interventions (which seek to address the impacts of the violence longer-term). The section does not cover legislated interventions, screening and risk assessment, protection orders and supervised contact conditions, or the criminal justice system response, all of which are researched in other reports.

The impacts of intimate partner violence on children and the likelihood of co-occurrence of intimate partner violence and child maltreatment are also well researched and documented elsewhere (e.g. Stanley, 2011; Partnerships Against Domestic Violence, 2004). This research has provided a profound rationale for intervening in children's lives when they have been exposed to partner and other family violence.

7.1 Principles to guide interventions with children

Reviewers have developed some key principles to guide interventions for children exposed to partner and other family violence. The literature is generally in agreement that interventions with children should:

- be guided by a strong understanding of the complexities of family violence (The Australian Domestic & Family Violence Clearinghouse, 2011)
- provide holistic support for children
- support the non-abusing parent
- support the mother-child relationship
- hold the perpetrator accountable
- be culturally responsive (Murphy et. al., 2013)
- provide integrated, collaborative and co-ordinated responses (Stapleton, undated; Murphy et.al. 2013).

Recent research on children's resilience in the face of trauma, and the variety of risk and protective factors in children's lives has led to questioning whether all children who have been exposed to family violence should be offered the same level of intervention (Van Heugten, 2008; Edleson, 2011). Rather, reviewers recommend the provision of a variety of responses along a continuum from those less affected to those highly affected by partner and other family violence (Humphreys, 2008).

Alongside the guiding principles outlined above, an Australian government review has identified the following essential features of interventions with children exposed to partner and other family violence:

- organisational support
- staff expertise

- regular staff support and supervision
- clearly articulated philosophy and conceptual framework
- adequate resourcing
- linkages to other sectors such as education (Partnerships Against Domestic Violence, 2004).

This section will now examine the evidence for effectiveness of each type of intervention which has been evaluated internationally, as well as any NZ examples.

7.2 Early intervention: integrated inter-agency response

When children's exposure to partner and other family violence becomes apparent, it is important that services are provided as soon as possible to ensure the child's safety (Schechter, 1999). However, in countries where children exposed to domestic violence are routinely referred to the statutory child protection agency (for example through mandatory reporting legislation or agency policies), the statutory system has become overloaded and there has been little improvement to child safety (Humphreys, 2008).

Partly in response to this problem, there has been a call for an integrated community response that includes co-ordinated and multi-component intervention (Stapleton, undated). This is discussed more fully in Section 3 above. The specific benefits for children are thought to be a better understanding of the risk to children from sharing information; shared awareness across multiple systems leading to better pathways into services; and more flexible approaches to meeting children's needs (Stapleton, undated).

How effective are multi-agency approaches for children?

In the North of England two early intervention projects with a multi-agency approach providing co-ordination, advocacy and case working following police referral have been evaluated. Victim advocates and child workers contacted the victim within 24 hours, providing risk assessment, safety planning and individual and group work to children. Voluntary perpetrator programmes were also provided. The services successfully reduced further reports of incidents, but other impact on children was not assessed (Stanley, 2011).

Success factors for multi-agency response for children

A 2008 Scottish review by Humphreys (2008) suggested that high level multi-agency domestic abuse partnerships should be goal directed, effective and accountable. They should also ensure that children's safety and well-being are central to the agenda (Humphreys, 2008). Other factors that can lead to success are having agency representation at senior levels, shared protocols, co-location, and integrated teams (Stanley, 2011).

In summary, there is strong international evidence that well implemented responses that include coordinated and multi-component intervention to victims, children and perpetrators result in better outcomes for families, including reduced violence. Co-ordinated intervention is also thought to lead to a better understanding of risk to children and more flexibility in meeting their needs, although more research is needed to investigate these benefits.

7.3 Advocacy for children

Advocacy for children who have been exposed to partner and other family violence takes a variety of forms. The 'Green Book', a long accepted guide for effective interventions for children affected by domestic violence observes that, overall, more than half of residents in women's refuges are children. It recommends that all intimate partner violence organisations should have well-trained, full-time advocates to provide services or refer children and their mothers to services (Schechter, 1999).

The NZ Advocates for Children and Young People who Witness Family Violence initiative placed child advocates within community based host agencies and aimed to provide an independent voice for children and young people, address their needs, and ensure that they had access to effective services. It also aimed to build collaborative relationships among agencies and increase public awareness of the impact of family violence on children and young people. Advocates provided individual case advocacy for children and young people, gave expert advice and guidance to family violence workers, worked with networks to co-ordinate services for children, monitored trends, and lobbied on behalf of children and young people (Centre for Social Research and Evaluation, 2009).

How effective is advocacy for children?

An evaluation of the initiative found that, despite some initial confusion about the role, advocates were effecting change at different levels. These ranged from changing individual family and whānau circumstances to raising public awareness. There was some evidence that children's voices were being heard and acted upon (Centre for Social Research and Evaluation, 2009).

The Child Crisis Intervention Project (CCIP) in Auckland provides a short-term crisis intervention service for children who have witnessed violence in their own homes. A child advocate visits the home over a three week period following reported violence.

An evaluation found an overall positive change in the wellbeing of just under half of the child participants during the three week period, based on mother's reports (Bennett, 2004). Mothers commented on positive changes in children's physical health and emotional behaviour, both at home and at school. Mothers interviewed considered that the CCIP had increased their awareness of the impact of domestic violence on their children's health and wellbeing. The majority of families/whānau (89% of mothers; 58% of children) had also received referral to support services.

Success factors for advocacy

The Centre for Social Research and Evaluation (2009) found that good advocates:

- have an explicit role and clearly defined boundaries
- are aware, empathetic, ethnically sensitive and knowledgeable
- are independent of service providers
- are soundly trained and supervised
- have a strong advocacy culture with a shared ethos of empowerment and support
- practice case-level and systems-level advocacy through lobbying and submissions
- are committed to review and evaluation.

In summary, advocacy has involved both casework and macro-level activities and the few evaluations show advocacy has resulted in some positive outcomes for children and mothers exposed to partner and other family violence, including in NZ. Attention to role clarity is important when implementing advocacy services.

7.4 Interventions for children in refuges

A UK review by Stanley (2011) examined the small amount of research on programmes provided for children when they are living in refuges. A period living in a refuge provides a key opportunity to assess a child's need for support and to link the family to appropriate services (Stanley, 2011).

Stanley identified the following types of interventions for children in refuges:

- Structured play to learn and practice coping skills, including expression through art
- Storytelling to offer empathy and demonstrate problem solving
- Music, dance and drama to learn new skills and express feelings
- Individual counselling
- Groups offering children opportunities to share their experiences
- Assistance with transition to new schools, as establishing normality in children's lives is critical.

How effective are interventions for children in refuges?

A US programme delivering play therapy to individual children and siblings in refuges found that mothers reported a marked improvement in behaviour problems and that aggressive behaviour was reduced in both groups of children, in comparison to a control group (in Stanley, 2011).

Success factors for interventions for children in refuges

Stanley suggests that to be successful, interventions for children in refuges need highly skilled staff, flexibility and responsiveness to children and young people, counselling and group facilitation skills, positive role modelling, worker support, a strong team approach with reflective practice, pleasant, home-like surroundings with a designated children's space, and linkages to other organisations which work with children (Stanley, 2011).

In summary, when children live in a refuge an opportunity is presented to intervene early to respond to the effects of children's exposure to violence. A small amount of research shows that intervention at this stage can reduce children's behaviour problems at least in the short term, provided facilitators are highly skilled.

7.5 Integrated interventions for mothers and children

Perhaps the most promising set of interventions examined for this review for children exposed to partner and other family violence are those which provide support for mothers and children together following reported family violence. There have been a number of

robust evaluations in this area. Two NZ interventions, one of which is provided for Māori children, are also outlined in this section.

Key aims of these interventions for mothers and children are to:

- engage the parent with the child's perspective on violence in the family (Stanley, 2011)
- break 'the conspiracy of silence' that can surround family violence, including within the mother/child relationship (Humphreys et al, 2006a in Stanley, 2011)
- help mothers to develop strategies to keep their children safe, help their children recover, and take care of themselves as survivors of abuse (Debbonaire, 2007 in Stanley, 2011)
- strengthen the caregiver-child relationship (Cargo et al, 2002)
- increase the mothers' knowledge about the effects of intimate partner violence on children.

The programmes typically aim to help children to:

- understand what domestic violence is, and that it is not their fault
- plan safety strategies
- deal with loss and change in a safe environment
- move on (Debbonaire, 2007 in Stanley, 2011)
- enhance their self confidence and sense of self worth (Cargo et al, 2002)
- learn conflict resolution skills
- improve trauma symptoms and functioning
- learn social skills (Rizo et al, 2011).

A similar intervention provided as a NZ example is the DoVe programme evaluated by Cargo et al in Taranaki in 2002. The providers co-facilitate groups of four to eight children bringing together children of similar ages and development levels, although siblings usually participate together. Eight structured sessions designed to strengthen the caregiver-child relationship are built in to the programme that offers music, posters and aromatherapy. On completion, a separate family/whānau session is held with each of the families in a group, which can include other significant members of the family but excludes the abusive parent (Cargo et al, 2002).

How effective are integrated interventions for mothers and children?

A number of mother-child interventions have been evaluated with positive results.

A US study offers strong evidence for this approach. Children aged 6 – 12 years who had been exposed to violence and their mothers were randomly allocated to a group programme for children only and a group programme with a parallel programme for mothers. Children's attitudes and levels of aggression were most likely to improve when both mother and child received a programme, compared with those who received the programme with no parent involvement and those on the waiting list who had not received a programme (Graham-Bermann et al, 2007 in Stanley, 2011).

The Sutton Stronger Families Group Programme in the UK individually assesses and runs concurrent 12 week groups for children and their mothers referred by a range of agencies. Children reported that they had learned about family violence and that it was wrong and not their fault. They had discovered that they were not alone in their experiences, and were more able to deal with their feelings and to communicate about their experiences (Debbonnaire, 2007 in Stanley 2011).

In Victoria Australia, the Parents Accepting Responsibility that Kids Are Safe (PARKAS) programme has common facilitators for mothers and children's groups (aged 8 – 12). There are common group experiences at the beginning, middle and end of the 10 week programme. Activities in the mothers and children's groups are run in parallel e.g. when children are asked to draw a family picture, mothers are asked to draw what they imagine the child would draw (Bunston, 2008 in Stanley, 2011). Pre-tests and post-tests with children, teachers and mothers showed children were experiencing fewer difficulties, fewer distressing emotional symptoms, and improved peer relationships. However, there was an increase in behavioural issues for some children. The facilitators suggested that these children were moving from internalising feelings to more overtly expressing their strong emotions (Bunston et al, 2008 in Stanley, 2011).

The Peeka Boo Club, offered by the same provider, works with mothers and infants up to 3 years of age. Mothers are encouraged in the group setting to identify their infants' emotional responses and to consider how exposure to family violence may be shaping their development. Mothers reported improvements in the quality of attachment between mother and child, reductions in hostility and increased enjoyment of their infant (Bunston et al, 2008 in Murphy et al, 2013).

The US Project SUPPORT intervention was designed for women attempting to establish households independent of their abusive partners and who had at least one child with conduct problems that merited a clinical diagnosis. Social and practical support was offered to mothers alongside a parenting skills component in weekly sessions for up to eight months after leaving the refuge. A two-year follow up of the 13 families taking part found fewer children with clinical levels of behaviour problems, fewer mothers using aggressive management strategies, and fewer mothers returning to their abusive partners, compared with the control group who received existing services (McDonald, 2006 in Stanley 2011).

In the UK the Talking to my Mum intervention developed activity packs which mothers and children work through together. One pack was developed for mothers and children in refuges and another for use in community settings. Early evaluation found that the materials evoked positive responses from families, but that some mothers needed support from refuge workers to acknowledge the extent to which their children had been exposed to and affected by the violence and to manage children's responses (Humphreys et al, 2006a in Stanley, 2011).

In a US child-parent psychotherapy programme children showed significantly fewer behavioural problems and traumatic stress disorder symptoms at the conclusion of a 50 week treatment programme, than children and mothers in the control group who received case management. The researchers concluded the mothers were more responsive and the children more trusting of the mothers' capacity to protect them (Lieberman et al, 2005 in Stanley, 2011).

Programme for Māori children exposed to family violence

He Taonga ngā Mokopuna is a programme developed from a kaupapa Māori base delivered in 10 sessions to sibling groupings in their own home with their caregiver present. The Māori facilitators share kai with the family, providing an opportunity to practice the cultural art of sharing kai. The facilitators 'sit with' and 'talk with' the children and the interaction and relationship that develops is a fundamental element of the programme.

The goals within the programme are:

- Tiaki – implementing safety and protection strategies
- Awhi manaaki – improving skills in social relationships
- Tu pakari – developing a sense of normality and a healthy self-esteem
- Tu tangata – understanding of their role in family violence
- Mana aouroa – understanding of changes and options after the violence became known
- Whakamana – developing strategies for non-violent conflict resolution and anger management
- Mana reo – expressing feelings
- Ngā wehenga, ngā ngaronga – dealing with separation and loss
- Te whānau whānui – building support networks
- Whakanui te whānau – strengthening bonds between child and whānau or caregiver (Te Puni Kōkiri, 2010).

The programme aims to empower children, ensure they link with a whānau member who will provide them with unconditional love, instill a sense of belonging, and the belief that he/she is important and valued, and the positive portrayal of mana wahine.

In an evaluation of He Taonga ngā Mokopuna, children who participated said they developed very good relationships with facilitators, and highly valued that facilitators were Māori. The children felt they learned most about self-esteem and least about getting on with siblings. Caregivers were highly satisfied with their relationships with the Māori facilitators (Cargo, 2002).

Success factors for integrated mother and children interventions

The effectiveness of these programmes can depend on:

- common leadership of the children's and mothers' components to help build communication
- the child's age (teenagers show the least improvement)
- longer duration of involvement
- the extent of inter-agency collaboration
- follow up support to ensure outcomes are sustained
- the skill, experience and supervision of staff (Rizo, 2011).

Factors that strengthened effectiveness of He Taonga ngā Mokopuna included having providers with considerable experience in working with Māori children and their whānau, having facilitators who highly identify as Māori and are able to work in te reo Māori. Referrals are facilitated by recognition that Māori children need a programme provided by Māori and by accurate recording of ethnicity on official documents such as court records so that Māori children in need can be identified (Cargo, 2002).

In summary, there is strong evidence from a set of robust evaluations that interventions which support mothers and children together are more effective than interventions which support mothers and children separately. These interventions are particularly valuable in that they engage the parent in the child's perspective of the experience of violence and can strengthen a range of important outcomes such as attachment, children's ability to express emotions, and a reduction in problem behaviours.

Although the longer term outcomes of He Taonga ngā Mokopuna were not evaluated, important factors for engaging mothers and children were having a kaupapa Māori basis and Māori facilitators with considerable experience in working with whānau.

7.6 Individual work with children exposed to intimate partner violence

Individual programmes seek to develop coping, safety, communication, conflict resolution and problem solving skills and increase children's understanding of intimate partner violence (Rizo, 2011).

Programmes typically incorporate safety planning with children, and include identifying a trusted adult who can be contacted in a dangerous situation, calling for help, finding a safe place in the case of violence, and not intervening in violent incidents (Mullener, 1996 in Stanley 2011).

It is important that children do not perceive a referral to an individual programme as a punishment for bad behaviour, but rather as a positive experience (Humphreys, 2008).

Counselling is one form of individual work with children. A Scottish review by Humphreys in 2008 identified the following frameworks and theories which underpin counselling practice with children exposed to family violence (Humphreys, 2008).

Understanding of attachment theory to address the disorganised and disrupted attachment that can be experienced when violence disables the child's mother and undermines the father's emotional involvement with the child (Prior and Glaser, 2006). This requires engagement with the non-offending caregiver to provide experiences through which a child can feel a more secure attachment to their parent (Miller, 2007 in Humphreys, 2008).

Recognition of the processes of loss and grief which confront children as they come to terms with the violence and abuse. This can include loss of a caring father, loss of their home, pets, friends and family networks (Mullender et al, 2002 in Humphreys, 2008).

Interventions which acknowledge children's traumatic reactions to seeing incidents of violence, recognising that children are profoundly affected by seeing violence perpetrated against their primary carer (Miller, 2007 in Humphreys, 2008) and may need intervention which goes beyond dealing with their immediate behaviour and cognitive reactions. It

recognises sleep disruption and fear as factors in the lives of many children affected by family violence.

Systemic and ecological analysis, which situates individual work with children within the wider context of their family, social and community networks. This recognises that most intervention with children and young people will need to address factors in their wider context and their relationships and not just focus on their internal world (Mullender et al, 2002 in Humphreys, 2008).

How effective are individual programmes with children?

Individual programmes in a range of pre/post test evaluations commonly show improvements in behaviour problems, self-esteem, attitudes to and knowledge of violence, anxiety, depression, aggression, social competence, knowledge of resources and safety, overall psychological well-being, and means of dealing with conflict (Rizo, 2011).

A programme whose overall aim was for children to accept that they were not responsible for the violence, and which involved play, art, pet therapy and safety planning, was evaluated in New Mexico. It found that about one third of the participants in the evaluation improved their ability to use a safety plan, extended their knowledge of what to do during a violent incident, and increased their ability to identify a safe adult (Ernst et al, 2008 in Stanley, 2011).

Success factors for individual programmes with children

In addition to being founded in the theories above outlined by Humphreys, individual programmes are most effective when offered to children severely affected by family violence and when they openly address the issues of violence in children's lives.

Humphreys identified an early study that recommended that individual work was offered especially to children with more chronic exposure to violence and more severe emotional and behavioural problems (Jaffe et al, 1990 in Humphreys, 2008).

It is important that the issues of family violence are addressed and that individual counselling does not only focus on the child's behavioural problems. This underlines the value of a thorough initial assessment which draws out the underlying issues (Jaffe et al, 1990 in Humphreys, 2008).

In summary, individual work which openly addresses the violence children have experienced is most suited to children who are more severely affected. A range of pre/post test evaluations show improvements in children's behaviour problems, self-esteem, attitudes and knowledge of violence, anxiety, depression, aggression, social competence, knowledge of resources and safety, overall psychological well-being, and means of dealing with conflict.

7.7 Group work with children exposed to intimate partner violence

Group work with children exposed to partner and other family violence has the benefits of addressing issues of secrecy, supporting children to feel less isolated, and strengthening

their peer relationships (Mullender et al, 2002 in Humphreys, 2008). Groups also allow the development of age appropriate themes and activities.

However group responses to children exposed to family violence have been criticised for providing a standard response to children from those who are less affected through to those who are highly disturbed by their exposure (Graham-Bermann, 2001 in Humphreys, 2008). Graham-Bermann suggests that group programmes focus on three areas: aggression, internalising problems, and problems in social relations.

Group work can be offered on a less clinical basis in youth clubs and community settings. In the UK, these types of programmes have developed resources such as videos and community arts activities (Humphreys, 2008).

How effective are group programmes for children exposed to family violence?

Several Australian programmes for adolescent boys who had been exposed to partner and other family violence have been positively evaluated. RAVE in Brisbane was an eight week group programme for boys aged 10 to 12 and 12 to 14 years, accompanied by a support group for mothers parenting adolescent boys. The evaluation found the programme achieved a change in perception as to who was responsible for violence, a sense of safety, management of anger and feelings of 'aloneness', improvement in school performance and family relationships, and an increased willingness to discuss personal experiences of family violence (Partnerships Against Domestic Violence, 2004).

RAGE in Melbourne involved boys aged 12 to 18 years and focussed on inequality of power between men and women, reinforced non-traditional roles, and encouraged respect, responsibility and choice. The programme was found to have successfully engaged the boys and led to behavioural and attitudinal change, building conflict resolution skills, having safety plans, goal setting, and improved ideas and experiences of masculinity (Partnerships Against Domestic Violence, 2004).

An Aboriginal narrative therapy programme was a culturally specific therapeutic programme with participants aged 13 to 21 years. Participants were assisted to develop an understanding of the impact of family violence and learn more appropriate life skills for dealing with anger and developing and maintaining relationships based on equality. An evaluation observed the complexities of working with numerous stakeholders, the value of reinforcing positive cultural identity, and the importance of developing non-violent skills (Partnerships Against Domestic Violence, 2004).

Success factors for group work with children exposed to family violence

Group programmes need a clear purpose and theoretical basis. They also need to assess and differentiate the needs of participants rather than delivering standard programmes to all.

In working with boys, it is important that programmes do not reinforce stereotypes that boys' behaviour is problematic, leading to the boys' belief that they are responsible for their experience of violence. The focus should be on assisting them to deal with their experiences of witnessing abuse rather than preventing boys from becoming violent (Partnerships Against Domestic Violence, 2004).

In working with boys, having strategies to actively engage them, such as adventure-based learning, also lead to greater effectiveness (Partnerships Against Domestic Violence, 2004).

In summary, pre and post-test evaluations show that group work has had benefits particularly for adolescent boys who have been exposed to violence. It is important that groups cater for the range of individual needs within the group and that the programme doesn't reinforce stereotypes that boys' behaviour is problematic, leading to the boys' belief that they are responsible for their experience of violence.

7.8 Parenting and home visiting interventions

Parenting interventions

Programmes that address men's role as fathers are a growing area of intervention for children exposed to intimate partner violence. Programmes aim to end intimate partner violence and increase fathers' understanding of the impact of violence on their children (Stanley, 2011). It is important to sequence interventions so that violent behaviours are addressed first, and to emphasise that 'you can't be a caring dad while being a violent partner'.

In NZ, Te Atawhainga te Pa Harakeke was a parenting programme delivered to Māori prison inmates. It aimed to enable the inmates to work through their own life experiences in order to understand their own parenting (Te Puni Kōkiri, 2010).

The Caring Dads programme was developed in Ontario and later established in several locations in the UK. Men had been referred by child protection services and a range of other organisations. Take-up was relatively low. Less than a half of those referred attended at least one session, and one third completed the full programme.

Pre and post assessment of the Caring Dads programme showed a reduction in fathers' hostility, denigration and rejection of their children and their level of angry arousal to child and family situations. The men's stress levels also reduced (Stanley, 2011; Rizo, 2011).

Factors increasing the likelihood of success of such programmes include facilitators being experienced in and knowledgeable about parenting practice and child development, having a balance of male and female facilitation, and providing good feedback to referring organisations (Stanley, 2011). For the Māori programme, a kaupapa Māori approach was seen as a key success factor as well as the facilitators being Māori with a strong identity and sense of whānau. It was important to use communication processes that worked for Māori and enabled Māori parents to make informed choices rather than imposing solutions on the participants (Te Puni Kōkiri, 2010).

Home visiting interventions

There is insufficient evidence to determine if home visitation reduces intimate partner violence but some promising results are emerging. A systematic review examining the home visitation and family violence relationship concluded that there was insufficient evidence to determine if early childhood visitation reduced intimate partner violence and that there is a need for further studies (Biluka, et al 2005).

Early Start in New Zealand found no significant differences between Early Start and Control families on measures of family violence at the three year and nine year follow-up studies (Fergusson et al, 2012). A combination of factors (parental reluctance to seek assistance; lack of services; parental non-compliance) was thought to explain the failure of Early Start to produce positive parent outcomes.

A study on the Hawaii Healthy Families Program has shown some promising results for reducing maternal partner violence. The paraprofessional home visitors provided direct services (teaching about child development, role-modelling positive parenting and problem solving strategies and emotional support) and linked families to community services such as shelters and advocacy groups and mental health services. Control mothers reported significant reductions in violence towards their partners during the three years of programme implementation. However differences between the control and comparison groups at the three-year follow up were not significant (Bair-Merrit et al, 2010).

Research is also underway on a multi-component intervention aimed at preventing intimate partner violence and delivered to first-time expectant mothers by Nurse-Family Partnership home visitors. The intervention consists of a structured assessment for intimate partner violence; a brochure-driven intervention for women experiencing intimate partner violence and safety planning (Niolon et al, 2009).

In summary, a pre and post test evaluation of a programme for fathers who are perpetrators of violence shows some improvement in their attitudes to their children, although take-up and attrition are problematic for these programmes. It is important to sequence interventions so that violent behaviours are addressed first and to emphasise that 'you can't be a caring dad while being a violent partner'. There is as yet insufficient evidence to determine whether early childhood home visitation reduces intimate partner violence.

7.9 Websites and helplines as interventions for children and young people

Research has shown that youth prefer to seek assistance through electronic sources. This is thought to be because young people have greater confidence in informal supports and comfort with electronic communication, and because the use of electronic media has less stigma than using formal less private supports (Van Heugten, 2008).

This preference has led to the development of websites, helplines and texting services, providing a significant source of support and information. However there has been little evaluation of these services (Humphreys, 2008).

In summary, websites and helplines are worth exploring as ways of reaching young people affected by violence since young people prefer to seek assistance this way, but little evaluation has been undertaken.

8. Family-centred interventions

This section details two major approaches to family-centred interventions for addressing intimate partner violence: family conferences and restorative justice, and couple counselling. An evaluation of Te Whare Ruruhau o Meri (Ōtāhuhu), which is aimed at reducing perpetrator offending, and includes victims and children in a whānau approach, is also included.

8.1 Description of family-centred approaches

The limited information identified on family interventions emphasises that such interventions are an area of contention for intimate partner violence as they move away from a traditional feminist approach (Stanley, 2011; Stith, Rosen, & McCollum, 2003). The primary concerns with family approaches are victims' safety, whether such approaches can effectively contain men's power and control behaviours, and the potential implication that the victim is at least partially responsible for the abuse.

Information that is available on family interventions is centred on family conferences, restorative justice and couple counselling. Stanley (2011) argues that the key factor for success in working with families is building trust, which is best achieved through small caseloads, provision of one key worker, and long-term involvement.

8.2 Family conferencing and restorative justice

Restorative justice proposes an alternative to the traditionally retributive criminal justice system based on perpetrator-oriented practices (Martin, unpublished; Liebmann & Wootton, 2010). Restorative justice approaches are intended to be victim-centred. The reported advantages of such approaches are that they are solution-based, rather than problem-focused, give voice to marginalised people, and focus on healing and reconciliation (Liebmann & Wootton, 2010).

Family conferencing (such as Family Group Conferences, Family Decision Making and Family Team Conferencing) is traditionally used for child safety in cases of child maltreatment, including cases of intimate partner violence (Carter, 2010). Family conferencing brings together families and community specialists to address family issues and create a safety plan to ensure safety and wellbeing of victims (Carter, 2010; Mills, Maley & Shy, 2009). The plan developed at the meeting makes clear what each person is committing to do to promote safety and wellbeing.

Family conferences are intended to reduce the secrecy that traditionally surrounds intimate partner violence, and increase the circle of people committed to stopping violence against a family member (Pennell & Burford, 2000; Liebmann & Wootton, 2010; Stanley, 2011). They can also foster relationships with community and social supports (Carter, 2010).

How effective is family conferencing and restorative justice?

No evidence reviews were identified for family conferences or restorative justice for intimate partner violence. Findings from two individual studies (a Canadian study of Family Group Decision Making, and a UK evaluation of the Daybreak Dove Programme) suggest some

positive results for decreasing child maltreatment, fewer children taken into care, decreasing abuse against mothers, and decreasing reporting contact with police[9] (Stanley, 2011; Pennell & Burford in Stanley, 2011). Feedback from families shows some positive reflections, with the majority of families in the Canadian study reporting they were "better off" as a result of the conference. The study concluded that family conferencing strengthens family ties, removes negative ties, and enhances the sense of being a family (Mills, Maley & Shy, 2009).

A NZ evaluation of restorative justice programmes for intimate partner violence cases reported the following outcomes:

- Most victims found the restorative justice meeting positive, noting that they:
  - understood what was happening
  - felt involved
  - were treated with respect
  - had the opportunity to express their views
  - were not scared to say what they wanted (Kingi, Paulin & Porima, 2008).
- Satisfaction with agreements reached in meetings (usually including counselling or programme attendance). However, victims tended to be less satisfied than perpetrators, noting that the perpetrator was unable to repair the harm, make up for what they had done, or they had got off too lightly.
- Mixed victim reports on whether the violence had stopped since the meeting. Some reported a cessation of abuse; others reported the abuse had changed from physical violence to psychological abuse.

Positive features of the restorative justice process, identified by victims include:

- Open dialogue
- Healing process
- Non-judgemental environment
- Being able to meet the perpetrator in a safe supported environment (Kingi, Paulin & Porima, 2008).

Assessing appropriateness for family conferencing

Overall the limited literature available at this time suggests family conferencing and restorative justice is most suitable for cases where victims want the violence to stop while continuing the relationship, victims want the conference/meeting, and there is a low level of risk (Carter, 2010; Kingi, Paulin & Porima, 2008). Kingi, Paulin & Porima (2008) concluded that restorative justice is most appropriately used for situations where:

- the violence is less serious
- perpetrators show remorse and accept responsibility for their offending
- victims and perpetrators are in an on-going relationship (or require an amicable relationship for childcare)

[9] While reduced reporting to police is presented as a success, without victims' self-reports of abuse it is unknown whether there was a change in abuse experienced subsequent to the intervention.

- perpetrators also participate in intervention programmes.

Carter (2010) produced guidelines for Family Team Conferencing with families living with intimate partner violence issues. There is no clear evidence-base for the guidelines, and they have not been tested. Due to the limited information available, key points are included here for consideration.

The guidelines emphasise the importance of a thorough risk and safety assessment of the appropriateness of conducting a conference, and whether perpetrators can safely be included. The assessment involves child advocates, intimate partner violence specialists, family members, and community service providers. It determines the nature and extent of the violence, and the impact on family members (Carter, 2010).

Perpetrators should not participate in conferences where victims do not want the perpetrator to attend, or where there are safety concerns. Potential concerns about perpetrator participation include:

- victim may feel limited in what they can safely say
- victim may give up trying to get what she wants and needs
- victim may agree to plans that she knows will put her or her children in danger
- perpetrator may try to manipulate the proceedings
- perpetrator may retaliate after the conference (Carter, 2010).

Follow up contact is required after the conference to assess any impact the meeting may have had on the victim or her children's safety, as the level of risk can change. The timing of the follow-up will depend on the level of risk assessed.

8.3 Te Whare Ruruhau o Meri (Ōtāhuhu)

Te Whare Ruruhau o Meri (Ōtāhuhu) delivers programmes aimed at reducing reoffending among 20 of Auckland recidivist offenders and their whānau referred by police (Roguski, 2009). The programme uses a whole whānau approach, including perpetrators (who are court-ordered to attend), victims and children.

Perpetrators are involved in a programme over 12 weeks, for two hours per week, finishing with a weekend wānanga. The programme is based on a philosophy of providing opportunities for perpetrator's empowered self-development. The women's programme is completely voluntary. It follows a similar format to the men's programme, without the weekend wānanga. The child component involves child-focused one-on-one and sibling counselling, and a school holiday programme.

How effective is Te Whare Ruruhau o Meri?

An evaluation of Te Whare Ruruhau o Meri has found that the programme is successful in reducing reported subsequent convictions. Based on police conviction data, the evaluation found that more than half of the perpetrators who participated in the programme did not have any reported subsequent convictions. Of those who did, most were not for domestic violence related offences with only five of the 41 perpetrators reoffending with domestic violence related offences.

Feedback from participants identified the following as the most significant impacts of the programme:

- no more violent offending
- learning pro-social ways of communicating
- positive impacts on family, such as changes in their children's behaviour (Roguski, 2009).

Critical success factors

The success of the programme is considered to be a result of interweaving core Māori values into the programme: whanaungatanga, manaakitanga, tikanga, wairua and aroha. Using three separate therapeutic whānau streams (perpetrators, victims and children), allows for:

- interventions to occur with whānau as a whole, not focusing solely on the perpetrator
- the development of a peer-relevant vocabulary for future whānau interactions
- each whānau stream to independently explore Ko Wai Au; and provide an opportunity for healing in safe peer-based group environments before whole-whānau interventions (Roguski, 2009).

The evaluation of Te Whare Ruruhau o Meri identified the following critical success factors for the programme delivery:

- engaging resistant populations
- the programme environment
- prioritising the male offender stream
- techniques of self-reflection and dialogue (Roguski, 2009).

8.4 Description of couples counselling

The use of couples counselling as an intervention for intimate partner violence is a contentious area, with concerns about victims' safety and the likelihood of victims carrying responsibility for the abuse. Couples counselling may not be appropriate for all incidents of intimate partner violence and more work is required to understand under what circumstances it should be used.

To determine who is suitable for couples counselling, Stith et al (2012) hypothesise that couple counselling should not be used for "characterological" perpetrators, where violence is a part of an effort to dominate and control. In these instances gender-specific treatments may be more appropriate due to safety concerns arising from the use of violence and coercive control. However, couples counselling may be suitable for "situational" perpetrators, where violence is used to exert control over specific interactions, not part of an overarching pattern of domination (Stith et al, 2012). This theory has not been tested and is presented here with caution due to a lack of available evidence. Further assessment and research is required. Other aspects need to be assessed to determine suitability such as the situational context in which the violence occurs.

How effective is couples counselling?

Findings from the experimental and quasi-experimental studies suggest that couples counselling has a positive effect on reducing the incidence of family violence, and does not increase victims risk of violence compared to individual treatment (Stith, Rosen, & McCollum, 2003; Stith et al, 2012). There are no indications of difference in effect for individual or group couple counselling (Stith et al, 2003; Stith et al, 2012). Further research is required to confidently assess the efficacy of couples' treatment for intimate partner violence, and to specify for whom couples counselling is effective.

In summary, there is limited information on the effectiveness of family interventions, which continues to be an area of contention. The evidence found focused on family conferences and restorative justice, and couple counselling. The limited information available suggests there may be some positive effects on reducing violence and child maltreatment. Further research is required.

Identifying who is suitable for family interventions is a key consideration to ensure victim safety. The literature currently suggests family interventions may be appropriate where victims want to remain with their partners, there is a low level of risk, the violence is less severe, and perpetrators take responsibility for their behaviour.

9. Discussion and conclusions

Adult victims and children who have experienced or been exposed to intimate partner violence have a range of immediate and longer term needs. They need help to recover from the trauma they have experienced and in the longer term, they may need to rebuild their lives. Above all they need the restoration of safety in their lives.

This paper has sought to find out what interventions might be most helpful in assisting women and their children to become safer and in helping them address the immediate and longer term consequences of experiencing violence, so as to increase their quality of life, and minimise accompanying health, social and economic consequences. Its purpose is to provide a shared view across Family Violence Taskforce agencies in relation to 'what works' for victims and children exposed to intimate partner violence.

Interventions for victims and children are part of a complex system

The interventions discussed in this paper represent only one segment of a large and complex system response to family violence. The system exists to hold offenders to account and rehabilitate them, and to support and protect victims and children. The entire system incorporates police and other front-line response, screening and risk assessment, family law response including protection orders and contact conditions relating to children, the criminal justice system response, as well as a variety of involvement from other sectors such as social services, health and education.

Perhaps the strongest conclusion that can be drawn from this report is that the overall response to family violence is most effective when it is integrated and co-ordinated. This entails all parts of the system, including the types of intervention discussed in this report, working together with common purpose, common understanding of family violence, common process, and shared information. There is strong evidence that when a high level of collaboration is achieved, violence is reduced.

Many of the interventions outlined in this paper have been designed and evaluated as discreet entities. It would be important that purchasing decisions considered not only the evidence for effectiveness of the discreet programme or intervention, but the propensity for that intervention to link in collaborative ways with other parts of the system, in accordance with known best practice in this area.

Features of good interventions

It is also important that programmes are well implemented and have strong organisational support. They should have skilled, experienced and supported staff with a deep understanding of the dynamics of partner and other family violence and access to clinical services. They should have a clear purpose and theoretical base and strong linkages to other services which support victims and children.

A variety of interventions to meet a variety of needs

The incidence and impact of intimate partner violence, children's exposure to intimate partner violence and child abuse are well documented elsewhere. Within the population who have been exposed to these types of violence, individuals will have a variety of different needs, including crisis response, immediate needs and longer term recovery needs. Therefore, we need to design response systems that are capable of addressing a

variety of needs at different points in time and in different locations and sectors. The provision of interventions is imperative in terms of minimising the long-term impacts of victimisation, and as an investment in prevention of on-going victimisation or perpetration in later life.

Responses should be tailored to reflect that victims and children are at different stages of coping and recovery in relation to their exposure to violence. Standardised interventions are less likely to engage their intended participant group, or to acknowledge participants' needs to determine their own solutions. Interventions should also acknowledge and work with differences in culture, age, level of trauma, and co-occurring issues particularly substance abuse and mental health disorders.

While a number of the interventions, such as refuges and safe homes, discussed in this report seek to restore immediate safety to victims and children, other tertiary interventions address longer term impacts. It is important to see outcomes, such as increases in self-esteem, peer support, and stronger bonding with children, as being of high value in their own right and as important for the longer term recovery of women and children. For example, it is hard to go out and get a job without a reasonable level of self-esteem. Without a job, it is hard to achieve the economic security necessary to support safe housing arrangements. Joint work to help the non-abusing parent and child recover from the consequences of violence is key to minimising trauma and on-going negative impacts.

Quality of the evidence

The quality of evidence for the interventions considered in this paper can be assessed across any combination of a range of dimensions, including the number of studies, size of studies and strength of design. Within the reviews, there are examples of robust outcome evaluations with comparative design and measurements over the longer term. However, many of the evaluations reviewed examine short-term outcomes only, involve small samples and have high attrition rates. Many of the NZ examples focus on how the intervention has been implemented and only a few measure outcomes.

The reviewers have chosen to qualitatively summarise the evidence for each intervention, rather than 'rate' the interventions according to the quality of evidence for their effectiveness. Rating may be misleading; partly because of the complexities of assessing quality, but also because quality of evidence is not the only factor to be considered in deciding which interventions should be funded. The interventions are seeking to achieve different outcomes to meet different needs. In reality, no single intervention will be sufficient and a variety of well integrated interventions is required. Moreover, the absence of evidence does not necessarily mean that an intervention is not effective, and may mean that more research is needed.

Future directions

Finally, one of the major reasons we don't have clear answers to the questions of what works is that most of the interventions have been developed in an ad hoc way, or implemented in piecemeal fashion, without sustained funding over time, both internationally and in NZ. Further, there has not been sufficient investment in a research programme to work alongside the interventions, to help develop and evaluate what is being implemented and outcomes achieved. As a consequence, we are not in a position to say which components of which programmes might be the most effective, or to assess if alternate delivery strategies might be more or less effective than the ones commonly used. Substantial further investment is needed in the development, implementation and evaluation of interventions, particularly within the NZ context.

References

Bennett S, ***An evaluation of the child crisis intervention project,*** New Zealand: Injury Prevention Centre, University of Auckland, 2004

Bennett L & O'Brien P, ***Effects of coordinated services for drug-abusing women who are victims of intimate partner violence***. Violence Against Women, 13, 395***,*** 2007

Bennet L & Bland P, ***Substance abuse and intimate partner violence***, Harrisburg: National Online Resource Center on Violence Against Women, 2008. Available from http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=1324

Bowker L H & Maurer L, ***The importance of sheltering in the lives of battered women***, Response to the Victimization of Women & Children, 8, 1, 1985.

Braaf M, ***Elephant in the room: Responding to alcohol misuse and domestic violence,*** Sydney: Australian Domestic and Family Violence Clearing House, University of New South Wales, 2012.

Brownell P & Heiser D, ***Psycho-educational support groups for older women victims of family mistreatment,*** Journal of Erotological Social Work, 46:3-4, 145-160, 2006.

Bunston W. ***Baby Lead the Way: Mental health group work for infants, children and mothers affected by family violence.*** Journal of Family Studies 14 (2-3) 334-341, 2008.

Cannon J & Sparks J, ***Shelters - an alternative to violence: A psychosocial case study.*** Journal of Community Psychology, 17, 203-21, 1989.

Cargo T et al, ***The Evaluation of Programmes for Children under the Domestic Violence Act 1995.*** Ministry of Justice, New Zealand, 2002.

Carter L, ***Family team conferences in domestic violence cases: Guidelines for practice***, San Francisco: Family Violence Prevention Fund, 2010***.***

Casteel C & Sadowski L, ***Clinical evidence: Intimate partner violence towards women,*** British Medical Journal Publishing Group, 2009.

Centre for Social Research and Evaluation, ***Advocates for children and young people who witness family violence.*** New Zealand: Ministry of Social Development, 2009. Unpublished

Centre for Social Research and Evaluation, ***Evaluation of the Family Violence Interagency Response System.*** New Zealand: Ministry of Social Development, 2003.

Constantino R, Kim Y & Crane P, ***Effects of a social support intervention on health outcomes in residents of a domestic violence shelter:*** A pilot study, Issues in Mental Health Nursing, 26, 575-590, 2005.

Cocozza J, Jackson E, Hennigan K, Morrissey J, Reed B, Fallot R & Banks S, ***Outcomes for women with co-occurring disorders and trauma: program-level effect, .*** Journal of Substance Abuse Treatment 28, 109–11, 2005.

Crespo M, & Arinero M, ***Assessment of the Efficacy of a Psychological Treatment for***

Women Victims of Violence by their Intimate Male Partner. The Spanish Journal of Psychology, 13, 2, 849-863. 2012.

Crichton-Hill Y, Coker V, & Taylor A, ***Reviewing domestic violence responses***: An analysis of Christchurch women's refuge contact data and how women access its services. Te Awatea Review, 8, 2010.

Debbonaire T (2007) ***An Evaluation of the Sutton Stronger Families Group Programme for Children Exposed to Domestic Violence. Executive summary of the findings.*** (Unpublished report.) London: London Borough of Sutton

Dutton D, ***Theoretical and empirical perspectives on the etiology and prevention of wife assault***, In Peters R D, McMahon J & Quinsey V L. (eds) , ***Aggression and violence throughout the lifespan,*** Newbury Park, CA: Sage, 1992.

Edleson J, ***Emerging Responses to Children Exposed to Domestic Violence .*** U.S.: Violence Against Women, National Resource Centre on Domestic Violence, 2011.

Ernst AA, Weiss SJ, Enright-Smith S and Hansen P. ***Positive Outcomes from an Immediate and Ongoing Intervention for Child Witnesses of Intimate Partner Violence.*** The American Journal of Emergency Medicine 26 (4), 2008.

Fallon P, ***Elder abuse and/ or neglect: Literature review***, Wellington: Ministry of Social Development, 2006.

Nam B, Waldvogel J, Stone G & Levine M. ***Family violence in migrant and refugee communities and successful models of prevention and intervention: A summary analysis and annotated bibliography,*** Wellington: Ministry of Social Development, 2011.

Fals-Stewart W & Kennedy C***, Addressing intimate partner violence in substance-abuse treatment***, Journal of Substance Abuse Treatment, 1, 5-17, 2005.

Fanslow J, ***Beyond zero tolerance: key issues and future directions for family violence work in New Zealand,*** Wellington: The Families Commission, 2005.

Fanslow J & Robinson M, ***Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand***, Journal of Interpersonal Violence, 25, 929-951, 2010.

Fergusson D, Boden J & Harwood J. Early Start Evaluation: Nine-year follow-up. Ministry of Social Development 2012 http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/evaluation/early-start-evaluation-report-nine-year-follow-up.pdf

Fowler D & Faulkner M, ***Interventions targeting substance abuse among women survivors of intimate partner abuse: A meta-analysis***. Journal of Substance Abuse Treatment, 41, 386-398, 2011.

Fowler D N, Faulker M, Learman J, & Runnels R, ***The influence of spirituality on service utilization and satisfaction for women residing in a domestic violence shelter.*** Violence Against Women, 17, 1244-1259, 2001.

Fry P S & Barker L A, ***Female survivors of abuse and violence: The influence of storytelling reminiscence of perceptions of self-efficacy, ego strength, and self-esteem***, In

Webster J D & Haight B K (eds) , ***Critical Advances in Reminiscence Work: From Theory to Application*** (pp. 197-217), New York: Springer, 2002.

Gilbert L, El-Bassel N, Manuel J, Wu E, Go H, Golder S, et al, ***An integrated relapse prevention and relationship safety intervention for women on methadone: Testing short-term effects on intimate partner violence and substance use***. Violence and Victims, 21, 657–672, 2006.

Glasgow K & Fanslow J, ***Family violence intervention guidelines: Elder abuse and neglect,*** Wellington: Ministry of Health, 2006.

Gondolf EW. ***A 30-month follow-up of court-referred batterers in four cities.*** International Journal of Offender Therapy and Comparative Criminology. 2000;44:111–28.

Goodkind J, Sullivan C M & Bybee D I, ***A contextual analysis of battered women's safety planning***, Violence Against Women, 10, 514-533, 2004.

Graham-Bermann SA. ***Designing Intervention Evaluations for Children Exposed to Domestic Violence: Applications of Research and Theory*** in Graham-Bermann SA and Edleson J (eds) Domestic Violence in the Lives of Children. Washington DC: American Psychological Association, 2001.

Graham-Bermann SA, Lynch SA, Banyard V, DeVoe ER and Halabu H ***'Community-based Intervention for Children Exposed to Intimate Partner Violence: An efficacy trial'*** Journal of Consulting and Clinical Psychology 75 (2) 199-209, 2007.

Gregg L, ***Collaboration in family violence intervention: A process evaluation of the Hamilton Family Safety Team.*** Thesis Master of Management Studies, Waikato University, 2007.

Gutierres S E & Van Puymbroeck C, ***Childhood and adult violence in the lives of women who misuse substances.*** Aggression and Violent Behavior, 11(5), 497-513, 2006.

Haar J, *He Pūrongo Arotake: Te Whakaruruhau Māori Women's Refuge. Evaluation Report: Te Whakaruruhau Māori Women's Refuge****,*** Wellington: Te Puni Kokiri, 2011.

Hager D, ***Finding Safety: Provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services,*** Home Works, 2010.

Humphreys C, Thiara R, Mullender A and Skamballis A ***"Talking to My Mum": Developing communication between mothers and children in the aftermath of domestic violence' Journal of Social Work*** 6 (1) 53-63, 2006

Humphreys C, ***Literature Review: Better outcomes for children and young people experiencing domestic abuse - Directions for Good Practice,*** Scotland, 2008.

Jaffe, P, Wolfe, D and Wilson, S. ***Children of Battered Women***. Newbury Park, Ca: Sage, 1990.

Jones A, Bretherton J, Bowles R & Croucher K, ***The effectiveness of schemes to enable households at risk of domestic violence to stay in their own homes: Research report***, London: Department for Communities and Local Government, 2010.

Kaslow N, Leiner A, Reviere S, Jackson E, Bethea K, Bhaju J, et al, ***Suicidal, abused African American women's response to a culturally informed intervention***. Journal of Consulting and Clinical Psychology, 78, 4, 449-458, 2010.

Keys F, ***Responding to Elder Abuse and Neglect: Assessment and referral procedures.*** Office for Senior Citizens, Wellington. 2003 (unpublished).

Kingi V, Paulin J & Porima L, ***Review of the delivery of restorative justice in family violence cases by providers funded by the Ministry of Justice,*** Wellington: Ministry of Justice, 2008.

Kubany E S, Hill E E & Owens J A, ***Cognitive trauma therapy for battered women with PTSD: preliminary findings***, Journal of Traumatic Stress, 16(1), 81-91, 2003.

Kubany E S, Hill E E, Owens J A, Lannce-Spencer C, McCaig M A, Tremayne K J, et al, ***Cognitive Trauma Therapy for Battered Women With PTSD (CTT-BW***, Journal of Consulting and Clinical Psychology, 72(1), 3-18, 2004.

Lieberman AF, Van Horn P and Ippen CG. ***Towards Evidence-based Treatment: Child-parent psychotherapy with pre-schoolers exposed to marital violence.*** Journal of the American Academy of Child and Adolescent Psychiatry 44 (12) 1241-8, 2005.

Liebmann M & Wootton L, ***Restorative justice and domestic violence/ abuse.*** HMP Cardiff and The Home Office Crime Reduction Unit for Wales, 2010.

Lyon E, Lane S, & Menard A, ***Meeting survivors needs: A multi-state study of domestic violence shelter experiences***, Harrisburg, PA: National Resource Centre on Domestic Violence. http://www.vawnet.org/research/MeetingSurvivorsNeeds/, 2008.

McDonald M, Rosier K***. Interagency collaboration – Part A: What is it, what does it look like, when is it needed and what supports it?*** AFRC Briefing No. 21–A Australian Family Relationships Clearinghouse 2011.
http://www.aifs.gov.au/afrc/pubs/briefing/b021/bp21a.pdf.

Mackness L***, Improving treatment paradigms for multi-abuse domestic violence clients***, Te Awatea Review, 6, 2, 2008.

Macy R & Goodbourn M***, Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: A review of the literature,*** Trauma, Violence and Abuse, 13, 4, 234-251, 2012.

Macy R, Giattina M, Sangster T, Crosby C & Montijoa N, ***Domestic violence and sexual assault services: Inside the black box,*** Aggression and Violent Behaviour, 14, 359-373, 2009.

Martin P, ***Restorative justice: A family violence perspective***. (Unpublished)

Martin J & Levine M, ***Safe@home Evaluation***, Ministry of Social Development, Wellington, 2010.

Miller, R. ***Cumulative Harm: a Conceptual Overview***. State of Victoria, Department of Human Services. 2007. www.dhs.vic.gov.au.

Mills L, Maley M & Shy Y, ***Circuloos De Paz and the promise of peace: Restorative justice meets intimate violence,*** N.Y.U Review of Law and Social Change, 33, 127, 127-152, 2009.

Ministry of Justice. ***Confrontational crime in New Zealand: Findings from the 2009 New Zealand Crime and Safety Survey***. Wellington: Ministry of Justice, 2010

Mullender A, Debbonaire T, Hague G, Kelly L and Malos E. ***Working with Children in Women's Refuges*** Child and Family Social Work 3 (2) 87-98, 1998.

Mullender A, Hague G, Iman U, Kelly L, Malos E and Regan L. ***Children's Perspectives on Domestic Violence.*** London: Sage, 2002.

Murphy, C. & Fanslow, J. ***Building Collaborations to eliminate family violence; facilitators, barriers and good practice.*** NZ Family Violence Clearinghouse Issues Paper 1, 2012.

Murphy C, et al, ***Policy and practice implications: Child maltreatment, intimate partner violence and parenting.*** NZ Family Violence Clearinghouse, Issues Paper 4, 2013.

Ministry of Women's Affairs. ***Speak Up, Seek Help, Safe Home: A Review of literature on culturally appropriate interventions for intimate partner violence in ethnic communities***, Wellington: Ministry of Women's Affairs, 2010.

Muftic LR, Bouffard JA. ***An evaluation of gender differences in the implementation and impact of a comprehensive approach to domestic violence***. Violence Against Women. 2007;13:46–69.

National Collective of Independent Women's Refuges. (2012). Annual Report: July 2011–June 2012. Wellington: NCIWR. Retrieved June 2013, from https://womensrefuge.org.nz/users/Image/Downloads/PDFs/NWR_Annual_Report_2012_WEB.pdf

New Zealand Family Violence Clearinghouse, ***Data Summary 1: Family violence deaths,*** New Zealand Family Violence Clearinghouse, May 2012.

New Zealand Family Violence Clearinghouse, ***Data Summary 2: Violence against women,*** New Zealand Family Violence Clearinghouse, May 2012a.

New Zealand Women's Refuge, accessed June 28, from https://womensrefuge.org.nz/WR/Home/Home.htm

Nicholas R , White M, Roche A M, Gruenert S & Lee N, ***Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia,*** National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, SA, 2012.

Orava T A, McLeod P J & Sharpe D***, Perceptions of control, depressive symptomatology, and self-esteem or women in transition from abusive relationships***, Journal of Family Violence, 11, 167-186, 1996.

Panchanadeswaran S & McCloskey L A***, Predicting the timing of women's departure from abusive relationships***, Journal of Interpersonal Violence, 22, 50-65, 2007.

Partnerships Against Domestic Violence, ***Children, Young People and Domestic Violence Phase 1 Meta-evaluation report.*** An Australian Government Initiative.

Pennell J & Burford G, ***Family group decision making: Protecting children and women.*** Child Welfare league of America, 2000.

Peri K, Fanslow J, Hand J, & Parsons J. ***Elder abuse and neglect: Exploration of risk and protective factors: A report for the Families Commission.*** Wellington: Families Commission, 2008

Ploeg J, Fear L, Hutchison B, MacMillan H, & Bolan G, ***A Systematic Review of Interventions for Elder Abuse,*** Journal of Elder Abuse & Neglect, 21:3, 187-210, 2013.

Prior, V and Glaser, D. ***Understanding Attachment and Attachment Disorders: Theory, Evidence and Practice.*** Jessica Kingsley Publications, London. 2006.

Ramsay J, Carter Y, Davidson L, Dunne D, Eldridge S, Feder G, Hegarty K, Rivas C, Taft A & Warburton A, ***Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse,*** Campbell Systematic Reviews, 2009.

Research and Evaluation Unit, ***Formative Evaluation of Family Safety Teams: an Overview,*** New Zealand: Ministry of Justice, 2008.

Rizo C M, ***A review of family interventions for intimate partner violence with a child focus or child component,*** Aggression and Violent Behaviour 16(2011) 144-166, 2011.

Robins K & Robertson N, ***Te Whakaruruhau Transition and Wellbeing Programme: An implementation evaluation,*** Hamilton: University of Waikato, 2008.

Robinson AL. ***Reducing repeat victimisation among high-risk victims of domestic violence: The benefits of a coordinated community response in Cardiff, Wales.*** Violence Against Women. 2006;12:761–88.

Roguski M, *He Pūrongo Arotake 2: Te Whare Ruruhau o Meri, Evaluation Report 2: Te* ***Whare Ruruhau o Meri,*** Wellington: Te Puni Kōkiri, 2009.

Saltzman L, Fanslow J, McMahon P, & Shelley G. ***Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 1.0.*** Atlanta GA: National Center for Injury Prevention and Control, Centers for Disease Prevention.1999.

Schechter S, et al, ***Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice,*** Reno, Nevada: The National Council of Juvenile and Family Court Judges, 1999.

Shepard M. ***Twenty years of progress in addressing domestic violence: An agenda for the next 10.*** Journal of Interpersonal Violence. 2005;20:436–41.

Slabber M***, Community-based Domestic Violence Interventions: A Literature Review***, Wellington: Department of Corrections, 2012.

Stanley N, ***Children experiencing domestic violence: A research review,*** Dartington: Research in Practice, 2011.

Stapleton J, ***The Mental Health Needs of Children Exposed to Violence in their Homes,*** The New Hampshire Coalition against Domestic and Sexual Violence, Undated.

Stith S, Rosen S, & McCollum E, ***Effectiveness of couples treatment for spouse abuse,*** Journal of Marital & Family Therapy, 29, 3, 407- 426, 2003.

Stith S, McCollum E, Amanor-Boadu Y & Smith D, ***Systematic perspectives on intimate partner violence treatment,*** Journal of Marital & Family Therapy, 38, 1, 220-240, 2012.

Stover C, Meadows A L, & Kaufman J, ***Interventions for Intimate partner Violence: Review and Implications for Evidence-based Practice,*** Professional Psychology: Research and Practice, 40, 3, p223-233, 2009.

Sullivan C, ***Evaluating domestic violence support service programmes: Waste of time, necessary evil, or opportunity for growth?,*** Aggression and Violent Behaviour, doi: 10.1016/j.avb.2011.04.008, 2011.

Sullivan C M, ***Examining the Work of Domestic Violence Programs Within a "Social and Emotional Well-Being Promotion" Conceptual Framework***, Harrisburg, PA: National Resource Center on Domestic Violence, Retrieved May 2013, from: http://www.dvevidenceproject.org, 2012.

Sullivan C M, ***Domestic Violence Shelter Services: A Review of the Empirical Evidence,*** Harrisburg, PA: National Resource Center on Domestic Violence, Retrieved May 2013, from: http://www.dvevidenceproject.org, 2012a.

Sullivan C M, ***Advocacy Services for Women with Abusive Partners: A Review of the Empirical Evidence,*** Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved April 2013, from: http://www.dvevidenceproject.org, 2012b.

Sullivan C M, ***Support Groups for women with abusive partners: A Review of the Empirical Evidence,*** Harrisburg, PA: National Resource Center on Domestic Violence, Retrieved May 2013, from: http://www.dvevidenceproject.org, 2012c.

Te Puni Kōkiri. ***Arotake tukino whānau: Literature review on family violence,*** Wellington: Te Puni Kōkiri, 2010.

Te Puni Kōkiri. ***Rangahau Tūkino whānau: Māori research agenda on family violence.*** Wellington: Te Puni Kōkiri, 2010a.

The Australian Domestic & Family Violence Clearinghouse, ***The Impact of Domestic Violence on Children: A Literature Review,*** 2011.

Tiwari A, Leung W C, Leung T W, Humphreys J, Parker B, Ho PC. ***A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong***, BJOG 2005;112:1249-1256.

Tutty L M, Bidgood B A, & Rothery M A***, Evaluating the effect of group process and client variables in support groups for battered women,*** Research on Social Work Practice, 6(3), 308-324, 1996.

Tutty L, ***Effective practices in sheltering women leaving violence in intimate relationships,*** Toronto Complete source?, 2006.

Tutty L & Rothery M, ***How well do emergency shelters assist abused women and their children?,*** In Tutty L, and Goard C (Eds.), Reclaiming self: Issues and resources for women abused by intimate partners (pp. 25-42). Halifax, NS: Fernwood, 2002.

Van Heugten K, et al, ***Building Resilience in young people who have witnessed intimate partner violence.*** New Zealand: Te Awatea Review, 2008.

World Health Organisation and the Centre for Public Health. ***Violence prevention the evidence: Reducing violence through victim identification, care and support programmes. Switzerland,*** World Health Organisation, Retrieved May 2013, from: http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/evidence_briefings_all.pdf, 2009.

World Health Organisation/INPEA***, Missing voices: views of older persons on elder abuse***, Geneva, World Health Organization, 2002.

Warshaw C, Sullivan C & Rivera E, ***A systematic review of trauma-focused interventions for domestic violence survivors,*** US: National Centre on Domestic Violence, Trauma and Mental Health, 2013.

Appendix 1: Methodology

Within the topic scope for the review, the searching process was defined by the following parameters:

- Published and grey material
- Documents published since 2005
- Documents from NZ, Australia, Canada, US, and UK
- Research-based evidence
- Restriction to existing literature/ evidence reviews, systematic reviews and meta-analyses.

Initial documents were provided by MSD, including some unpublished material and internal documents. A search of electronic databases and websites was then undertaken.

Database search

Multiple searches were conducted by a librarian from the Ministry of Social Development. The following databases were used for this search were:

- The New Zealand National Union Catalogue, Index New Zealand, Social Care, EbscoHost Research Databases, ProQuest (which includes Psychology Journals, Sociological Abstracts, and Social Services Abstracts); Austrom (a suite of Australian databases), Campbell Collaboration, The Cochrane Library, and PubMed.

The keywords used in various combinations for this search were:

- family OR domestic OR partner OR spous* OR wife OR marital OR abused
- violence OR abuse OR wives
- prevent* OR program* OR interven* OR initiative* OR approach* OR support* OR campaign* OR treatment* OR strateg* OR reduc* OR rehabilit* OR trial* OR therap* OR psychotherap* OR pilot*
- effective* OR effica* OR success* OR best OR works OR evaluat* OR analy* OR meta* OR longitudinal OR review* OR empirical OR outcome* OR strength* OR evidence* OR impact*
- victim* OR elder* OR female* OR women* OR wives OR wife OR spouse* OR witness* OR indigenous OR ethnic* OR refugee* OR minorit* OR adolescen* OR poverty OR depriv* OR poor OR collaborat* OR multi-agenc* OR ses OR interagenc*OR mental* OR head OR drug* OR substance* OR alcohol* OR cognitive* OR holistic* OR whanau OR maori OR pacific

The search of databases produced a total of 278 articles that met the search criteria. A critical evaluation of this literature was undertaken against the over-arching search aims.

The abstracts of all 278 articles were critically reviewed, and a resulting 67 articles were identified as relevant and full text copies were sought. Some articles could not be accessed in full text within the time available or were later deemed out of scope, resulting in 53 full text articles that were included for review in the analysis stage. The review of articles targeted existing literature reviews, systematic reviews or meta-analysis, rather than

primary studies. Primary research studies were included were there were gaps in evidence or to include a NZ perspective.

Full text articles were analysed against the review questions. Further reports were identified from the reference lists of key documents and accessed in full text.

Web-based search

Internet searches were undertaken to obtain published and unpublished papers, research reports, practitioner-based and organisational documents. A search of government and non-government agency websites, and clearinghouses was conducted, including:

- Australian domestic and family violence clearinghouse
- Australian Institute of Criminology
- Campbell Collaboration
- Google scholar
- Ministry of Social Development
- National Online Resource Centre on Violence Against Women (VAWnet)
- New Zealand Family violence Clearinghouse
- PreVAil (Preventing Violence Across the Lifespan Research Network)
- Public Health Agency of Canada
- Te Puni Kōkiri
- The Domestic Violence Evidence Project
- The Ministry of Justice
- The Ministry of Women's Affairs
- The Violence Prevention Alliance (VPA) Network
- The World Health Organisation
- WAVES (Waitakere Anti-violence essential services).