What Works to Prevent Intimate Partner Violence and Elder Abuse?

Report to Ministry of Social Development

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Acknowledgements

Summary

What works to prevent intimate partner violence and elder abuse?

This paper synthesises research evidence on preventing intimate partner violence and elder abuse before violence occurs. Quigley and Watts Ltd conducted this review for the Ministry of Social Development. The review is part of the Taskforce for Action on Violence within Families' Programme of Action 2012/2013.

Important messages from this review

1. A strong case supports the need for primary prevention

International researchers agree that preventing violence before it occurs – primary prevention – is crucial and attainable (World Health Organization 2013, Bellis et al 2012, World Health Organization 2010, VicHealth 2007). Many countries, e.g. Australia and the US, are strengthening their focus on primary prevention.

Intimate partner violence and elder abuse are major problems that harm families and whānau, individuals, and communities, as well as New Zealand's social and economic status. In light of the widespread and serious impacts, we cannot afford *not* to invest in preventing violence before it occurs (World Health Organization 2013 and 2010, Bellis et al 2012, VicHealth 2007).

2. Primary prevention is an emerging field with many promising practices

Research on the primary prevention of intimate partner violence and elder abuse is in its early days, particularly for sexual violence and elder abuse. In New Zealand, most primary prevention programmes are not yet evaluated.

Though we do not yet have all the answers, there is much we can do towards preventing violence before it occurs. Researchers say there are other grounds to support primary prevention while the field is under-evaluated – e.g. where programmes are theoretically sound, feasible, successfully implemented, and where they address known risk and protective factors (World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007). Much promising work is underway locally and internationally which needs to be tested and expanded (World Health Organization 2013).

3. The prevention of complex problems takes time and requires cross-sector involvement

The primary prevention field is evolving. It will require ongoing development and investment over time. Researchers stress that change in this area needs time; there is no quick fix (e.g. Quadara and Wall 2012, VicHealth 2012b, Casey and Lindhorst 2009, VicHealth 2007).

Multi-faceted primary prevention programmes need be trialled for sufficient time to show results. This is better than implementing short-term programmes which address a single influence on violence. Cross-sector, multi-agency prevention is required to address the complex causes of and impacts on intimate partner violence and elder abuse.

Summary of findings

Our review focuses on five primary prevention approaches: societal-level, community-level, indigenous-led, alcohol-related, and child and youth-focused. The Ministry of Social Development requested these areas of focus. The review has found that all five approaches are thought to have good promise, and some examples of evaluated success have shown reductions in intimate partner and sexual violence.

Note: Family support and parenting programmes, as well as school-based programmes, are excluded from this review because other current work covers these. This means that some key effective interventions are not detailed here.

Preventing intimate partner violence

Research into the effectiveness of primary prevention of intimate partner violence is in its early stages, but positive evaluation findings are emerging. At a societal-level, researchers recommend strategies to change social norms on violence and gender roles, and to reduce gender discrimination. Evaluation suggests that steps can be taken toward societal change, e.g. US federal funding to address violence against women, media advocacy, and policies to reduce access to alcohol. International researchers argue that reducing general harms from alcohol is likely to help prevent violence before it occurs (e.g. Bellis et al 2012, World Health Organization 2010).

Examples of evaluated community-level prevention include: community development[1] and mobilisation; bystander approaches; targeting men and boys (e.g. the Men's Program in the US); and community social norms and social marketing approaches. Social marketing campaigns can be effective if multi-level and comprehensive, e.g. the "It's Not OK" campaign in New Zealand.

Indigenous-led prevention

Indigenous-led primary prevention is currently under-researched in New Zealand and overseas. However, some evaluated evidence is available and much preventive work is underway. Based on indigenous literature and existing evaluations, approaches likely to be effective in New Zealand include:

- Kaupapa Māori approaches

- strengths-based and community development approaches

- cultural and family/whānau strengthening

- integrating cultural and clinical competence (Cooper et al 2012, Victoria Department of Human Services 2012, Success Works 2011, Shea et al 2010, Memmott et al 2006).

Indigenous researchers highlight the need to address the intergenerational and continuing impacts of structural factors, like colonisation and racism, as part of indigenous primary prevention. Evaluated New Zealand primary prevention programmes include the Ngāti Porou Community Injury Prevention project (Cooper 2012, Shea et al 2010), and Amokura Family Violence Prevention Strategy, which both showed positive results (Grennell and Cram 2008).

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[1] Community development is defined as communities working together to identify their own needs and to create shared solutions to meet those needs

Promising programmes include: 'E Tu Whānau!' social marketing campaign; Tiaki Tinana sexual violence prevention; the iwi-led Ngāti Kahungunu Violence Free project; and Waananga Whakamana, a marae-based programme for high-risk offenders and their whānau. As noted, some effective programmes may have been missed in this review, as they target child maltreatment or whānau and parenting support.

Preventing elder abuse

Our review found far less information on elder abuse than on intimate partner violence – because there are very few primary prevention interventions worldwide. Elder abuse researchers recommend: primary prevention interventions to change social norms on gender and ageing; preventive community development approaches (e.g. engaging older people and working at the neighbourhood level to create elder-friendly communities); reducing alcohol-related harm; and reducing family and caregiver stress.

Elder abuse researchers call for the involvement of older people in developing prevention programmes, and for more collaboration between the partner violence and ageing sectors. They stress the need to address ageism as an underlying contributor.

In New Zealand, we lack adequate information about the prevalence and impacts of elder abuse and neglect. The problem is predicted to rise in the future, given our ageing population. Crucially, the issue requires more attention and investment.

What elements are common in successful programmes?

Success factors for primary prevention in this area include:

- comprehensiveness, e.g. multi-level approaches (societal, community, family/whānau, individual)

- being based on a theory of change (e.g. Māori or Pacific conceptual frameworks, stages of change theory, social-psychological theory, ecological and systems theory)

- contextualised programmes which are locally-designed and culturally-specific

- positive strengths-based approaches

- community-driven interventions including cultural leadership and involvement

- addressing of structural factors (e.g. gender inequality, income inequalities, racism, ageism) and

- incorporating impact evaluation.

Community and societal prevention

The review confirms that ecological and cross-sector approaches are widely accepted to inform primary prevention (i.e. strategies across individual, relationship, community, and societal levels, and involving multiple partners).

Existing evaluations tend to be on individual and family-level programmes more than community and societal-level. Yet leading experts stress that these broader levels hold the most promise (World Health Organization 2013, DeGue et al. 2012a, Quadara and Wall 2012, Casey and Lindhorst 2009). Drawing on

evidence, they highlight the need to address the economic and sociocultural factors that foster a culture of violence against women. Challenging social norms that support male authority and control over women, and which sanction or condone violence against women, is also important.

Policy and legislative interventions to improve the general social and economic situation of Māori and Pacific peoples, and to reduce socioeconomic disadvantage across groups, are likely to help prevent violence before it occurs. Intimate partner violence is closely linked with macro-level factors like socio-economic inequalities, unemployment, and access to education. However, it does occur across the full socio-economic spectrum.

Māori-led approaches

Māori-led approaches, and partnerships involving Māori, must be prioritised in New Zealand, based on early evidence of effectiveness and indigenous best practice. A number of positive initiatives are already underway, e.g. 'E Tu Whānau!' campaign, 'Tiaki Tinana' and iwi-led initiatives. Further development, resourcing, and evaluation of Māori-led approaches is required.

Recommended areas of focus in the literature

Three particular approaches are highlighted as promising:

- A focus on **children and young people** – in the context of families, whānau, and communities – has good potential for preventing violence before it occurs. It is vital to target children and youth at higher risk (e.g. those who have experience of or exposure to violence) and to provide adequate and appropriate support to families and whānau.

- Positive **strengths-based** approaches – e.g. positive youth development has improved a range of youth outcomes. Focusing on strengths, e.g. cultural identity, values and practices, is emphasised as promising in indigenous literature.

- Primary prevention with **men and boys**, within family, whānau, and community contexts. Growing research supports male-focused prevention, such as men's groups and male anti-violence campaigns, and the use of men as positive, non-violent role models (e.g. the involvement of sports clubs in primary prevention strategies to influence male attitudes and behaviour, and to challenge gender norms that influence violence).

All three areas appear to be consistent with indigenous and ethnic minority models of wellbeing and existing Māori-led and Pacific-led prevention strategies.

Integrated approach to primary prevention

Many researchers criticise the 'siloing' of distinct forms of violence prevention and research – e.g. intimate partner violence, youth violence, sexual violence, child maltreatment etc. Such divisions are appropriate in responding to and treating violence, but may be less useful for preventing violence before it occurs.

Individuals, families, whānau, and communities often experience more than one type of violence and the various forms of violence share many of the same risk and protective factors. Adopting a more integrated approach, e.g. interagency collaboration to prevent all forms of violence, would also be more consistent with Māori and Pacific models of wellness.

Suggested areas for action

Based on our review, we suggest these next steps for primary prevention in New Zealand:

1. Develop a national framework for the primary prevention of family violence.

2. Continue to resource, support, and evaluate the impacts of existing promising programmes in New Zealand, e.g. the 'It's Not OK' campaign, 'E Tu Whānau!', and 'Pasefika Proud' campaigns.

3. Prioritise the development and expansion of primary prevention strategies at community and societal levels, aiming to change social and gender norms. Important community and/or societal approaches highlighted in this review include:

    *   Māori-led and Pacific-led strategies that encourage community and societal-level change
    *   community development and positive youth development aiming to improve various outcomes, including all forms of violence
    *   primary prevention focused on men and boys in the context of families, whānau, and communities
    *   changes to policies and legislation to reduce alcohol-related harm in general, and
    *   multi-agency, cross-sector primary prevention strategies that take an integrated approach to violence and target change at community and societal levels.

4. Explore the potential to adapt successful primary prevention programmes from overseas to a New Zealand context, beginning by piloting programmes that have been evaluated as effective.

5. Build on this review to identify more specifically the most effective content and delivery strategies for primary prevention programmes.

Conclusion

The World Health Organization (2013) calls for "a major scaling up" of global efforts to prevent all kinds of violence against women. Drawing on a comprehensive global analysis, it states:

> *Violence against women is not a small problem that only occurs in some pockets of society, but rather is a global public health problem of epidemic proportions, requiring urgent action (World Health Organization 2013, p3).*

A compelling case exists for preventing intimate partner violence and elder abuse before they occur, despite the imperfect research base. The consequences of partner violence and elder abuse are so immense that primary prevention must not be seen as an optional extra.

At the same time, appropriate, high quality services must be available to those who experience intimate partner violence or elder abuse. It is vital to properly resource secondary and tertiary responses to violence (e.g. treatment and support services for victims, early intervention, preventing recurring violence, treatment for perpetrators).

Intimate partner violence and elder abuse have serious and often long-term adverse effects – and escalating social and economic costs. Money spent today on primary prevention will save lives and money in the future.

1 Introduction

1.1   Purpose of this paper

This paper summarises research evidence on preventing intimate partner violence and elder abuse before violence occurs (i.e. primary prevention). We include selected, illustrative programme examples, from New Zealand and other countries, with known or emerging effectiveness. We also discuss recent shifts in thinking about what works and critical success factors of prevention programmes.

As the Ministry of Social Development requested, the review focuses on five areas of the primary prevention literature:

- societal-level prevention, e.g. changing social norms, policy, and legislation
- community-level prevention, e.g. community development and bystander interventions
- indigenous-led approaches
- interventions to prevent alcohol-related partner and elder violence, and
- prevention focused on children and young people.

This work is part of the Taskforce for Action on Violence within Families' Programme of Action 2012/2013. It will inform future work to guide investment in effective primary prevention of family violence in New Zealand.

Audience

Taskforce members are the intended primary audience. A wider audience comprises agencies, communities, and individuals interested in violence prevention.

Related projects

Related projects on primary prevention of family violence are being led by the Ministry of Women's Affairs, Ministry of Education, and the Families Commission. To reduce duplication, our review excludes areas covered by these projects (e.g. interventions to prevent child maltreatment, school-based primary prevention programmes, and parenting and family/whānau support programmes).

Ideally, our review should be read in conjunction with these other papers. Though out of scope for this review, primary prevention in these areas is supported by evidence and should be part of a comprehensive primary prevention strategy.

Two forms of violence

The Ministry of Social Development sought a review focusing on intimate partner violence and elder abuse in particular, rather than a broader review covering all forms of family violence. There is some overlap and synergies between the two forms of violence, however there are also key differences (e.g. elder abuse is influenced by ageist assumptions and social norms on ageing).

Structure of this paper

This paper begins by defining key terms including intimate partner violence, elder abuse, and primary prevention. It describes the review's scope as well as strengths and limitations. We then provide

contextual information on the prevalence and impact of violence in New Zealand, and discuss key shifts in thinking about what works in primary prevention.

Next, we summarise the latest evidence on the effectiveness of primary prevention and give examples of effective and promising practices in New Zealand and overseas. The final section sets out common elements of good programmes (i.e. success factors), and is followed by a conclusion.

1.2   What is partner violence and elder abuse?

Terms for violence vary in the prevention literature and in practice, often without universally-accepted definitions. Understandings of violence can and do change over time. In light of the continuing debate and diversity in definitions, we set out the following definitions for this review. Indigenous understandings of violence can differ from generic terms. We discuss indigenous definitions from New Zealand and overseas below. Our definitions are consistent with public health literature and the latest thinking in New Zealand (e.g. Ministry of Women's Affairs forthcoming a, Cooper 2012).

Note: The term 'survivor' is preferable to 'victim' from an empowerment perspective; however in this review we generally use the term victim to recognise the devastating impacts of violence and its common use in international literature.

Intimate partner violence

Intimate partner violence is defined as violence within intimate relationships including spouse, de facto partner, and dating relationships. It includes sexual violence. This is consistent with international definitions, e.g. the World Health Organization (2010) specifies physical, sexual or psychological harm by a current or former partner or spouse. Inclusion of sexual violence is appropriate as most sexual violence happens within intimate relationships (Robertson and Oulton 2008, VicHealth 2007).

The term also covers the systematic use of threats or coercion to instil fear and control partners, as well as intimidation, stalking, and financial abuse (Ministry of Women's Affairs, forthcoming a). Intimate partner violence can occur among heterosexual or same-sex couples.

Elder abuse and neglect

Elder abuse and/or neglect is defined as "when a person aged 65 years or more experiences harmful physical, psychological, sexual, material or social effects caused by the behaviour of another person with whom they have a relationship implying trust" (Age Concern New Zealand, cited in Ministry of Women's Affairs forthcoming b).

Elder abuse may be intentional or unintentional and includes acts of omission or neglect (Ministry of Women's Affairs, forthcoming b). Financial or other material abuse is included. Betrayal of trust by people in a position of power or responsibility for the care of the older person is a key element in elder abuse (Lievore and Mayhew 2007).

Abuse may occur in domestic or institutional contexts. In New Zealand, it has been estimated that some 70% of instances of elder abuse and neglect are perpetrated by family/whānau members. Data from Age Concern shows that two-thirds of perpetrators over the age of 65 were partners of the victim (Lievore and Mayhew 2007), indicating a large overlap between intimate partner violence and elder abuse.

Defining indigenous violence

Indigenous authors tend to prefer the term 'family violence' – over intimate partner violence or domestic violence – to reflect the involvement of the wider family and community (Success Works 2011, Shea et al 2010, VicHealth 2007, Memmott et al 2006). This broader understanding acknowledges that violence causes suffering for the whole family, including perpetrators.

Whānau violence

Māori literature argues that because whānau violence has a wider meaning than nuclear family violence, it covers a wider scope of issues and may require different approaches to prevention (Cooper 2012, Te Puni Kōkiri 2010). Māori researchers say that failure to understand the broad nature of whānau will inevitably lead to the failure of family violence prevention efforts (e.g. Cooper 2012).

Current family violence literature and legislation in New Zealand lacks recognition of the holistic understanding of whānau, and a shared understanding of whānau violence is yet to be agreed (Cooper 2012, Te Puni Kōkiri 2010). A review of indigenous literature noted that defining whānau violence is complex and needs to include analysis of the impacts of structural factors like colonisation and racism (Te Puni Kōkiri 2010).

One Māori researcher (Erana Cooper, Ngāti Hine) has offered this definition of whānau violence, based on PhD research in Northland and a review of indigenous literature:

> Whānau violence can be defined as any form of spiritual, psychological, sexual, or physical abuse and neglect that is experienced by any individual or collective of individuals who constitute whānau, where whānau is defined broadly to include all individuals linked by whakapapa or other close connection, including extending to the hapū and iwi. Whānau violence results from negative and conflicting values, beliefs, attitudes and behaviour that are the result of a complex interaction of factors occurring within the context of both historical and contemporary trauma or stress (Cooper 2012).

The role of gender in intimate partner violence and elder abuse

Most intimate partner violence involves men's violence against women (World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007). It can also be perpetrated by women toward men, but this is less likely.

Debate over gender has tended to be polarised in two camps: those who frame intimate partner violence as mainly perpetrated by men – the 'extreme asymmetry' stance – and those who believe that men and women are equally violent toward partners – 'gender parity' (Hamby 2009).

An international review of meta-analyses and prevalence information argues the evidence supports a third option – a 'moderate asymmetry' explanation (Hamby 2009). According to that review, data consistently shows that women commit 20% to 35% of *physical* intimate partner violence. This indicates that most perpetrators are men, and endorses neither gender parity nor strongly asymmetrical explanations (Hamby 2009). This picture aligns with the research into other forms of violence (Hamby 2009) and is consistent with New Zealand's national victimisation survey and administrative data (Lievore and Mayhew 2007).

The perpetuation of *sexual* violence, however, shows stronger differences in gender, particularly for serious sexual violence. For instance, criminal data in the US suggests that female perpetrators commit well under 10% of sexual offences (Hamby 2009).

Some recent studies suggest that rates of adolescent relationship violence perpetration may be more similar for young men and women, compared to older age-groups (Leen et al 2013, Lievore and Mayhew 2007). But many researchers acknowledge that if severity and injury are taken into account, young women are more likely than young men to be victims of physical and sexual violence (Hassall and Hanna 2007, Leivore and Mayhew 2007). In general, it is universally accepted that men inflict injury against partners more than women (Hamby 2009).

Likewise, New Zealand and overseas data suggest most victims of elder abuse are women (Norris et al 2013, Lievore and Mayhew 2007), and also that some women are perpetrators of elder abuse and neglect. It is thought that women are more likely to perpetrate neglect rather than abuse (Lievore and Mayhew 2007).

On balance, the evidence appraised for our review shows that gender is a central issue affecting elder abuse and intimate partner violence, for both physical and sexual violence.

Related terms

Violence against women and *gender-based violence* are other relevant terms. *Violence against women* is an abuse of power that is facilitated by gender inequality and may occur within families as well as in the general community (Ministry of Women's Affairs, forthcoming b).

Gender-based violence is a broader, developing term which acknowledges that violence is related to the gender of both victim and perpetrator, and to male social power (Ministry of Women's Affairs, forthcoming b). Victims may be of either gender, but most cases involve a female survivor and a male perpetrator. Most violent acts against boys and men are also committed by male perpetrators (Ministry of Women's Affairs, forthcoming b).

Overlapping forms of violence

There are overlaps in the literature between intimate partner violence, sexual violence, youth violence and child maltreatment. Youth violence is closely linked with intimate partner and sexual violence. The prevalence and frequency of violence peaks in late adolescence to early adulthood (Fagan and Catalano 2012). Young New Zealand women are almost twice as likely to experience sexual violence, compared with older women (Dickson 2013). This is consistent with overseas data (Quadara and Wall 2012, Casey and Lindhorst 2009).

Intimate partner violence often co-occurs with child maltreatment. US data shows that over a third of children who witnessed intimate partner violence had also been subjected to child maltreatment themselves, compared with 9% of those who had not witnessed intimate partner violence (Murphy et al 2013a).

So, our review refers to some findings on the primary prevention of youth violence and child maltreatment. An inclusive approach is also appropriate because preventing *all* forms of violence and abuse, especially child maltreatment, will help to reduce the levels of partner and sexual violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

1.3 What is primary prevention?

Primary prevention aims to prevent violence before it occurs, usually focusing on populations not individuals. It is the most desirable form of prevention but the most difficult to achieve (VicHealth 2007). In light of the multiple factors that contribute to violence, primary prevention activities may not always have an explicit focus on violence, e.g. initiatives to address income or gender inequality may prevent violence before it occurs.

In contrast, *secondary prevention* is a crisis response immediately after violence has occurred, aiming to prevent short-term impacts and re-victimisation, as well as preventing repeat offending or escalation of violence (Ministry of Women's Affairs, forthcoming b). *Tertiary prevention* refers to longer-term responses to violence, e.g. reducing long-term negative impacts on victims, and preventing repeat offending and escalation in future.

Researchers say that in reality the three levels of prevention may overlap. For instance, the deliverers of a school-based programme to prevent relationship violence before it occurs cannot be certain that all participants have not already perpetrated, or been victims of, such violence (Carmody et al 2009).

Universal and selective (targeted) interventions

Primary prevention approaches are either universal or selective (targeted). *Universal interventions* are aimed at the whole population, or groups within it (e.g. gender or age-groups), without regard to individual risk of violence perpetration or victimisation. Social marketing campaigns and programmes in schools are examples.

Selective (or targeted) interventions focus on groups at heightened risk of becoming perpetrators or victims of violence in the future, e.g. children who have experienced or been exposed to family violence, gang members or homeless young people.

1.4 What is effectiveness?

Defining effectiveness is important. To 'prove' effectiveness, rigorous evaluations are required – e.g. randomised controlled trials or quasi-experimental designs that involve pre and post measures to show positive changes in outcomes, ideally over the longer term and in various contexts. Experimental evaluations typically compare the outcomes of an intervention group, which takes part in a programme, with a similar control or comparison group (World Health Organization 2010).

However, this approach is not the only way to assess effectiveness. International experts propose additional ways to gauge success (VicHealth 2007). Prevention programmes can be informed by broader evidence, e.g. through addressing known risk and protective factors for intimate partner violence and elder abuse, and by learning from existing evaluations and theoretical explanations. Process evaluations can offer evidence of implementation, and shed light on the reach, acceptability, and feasibility of interventions (VicHealth 2007).

Note: Interventions with proven effectiveness are not necessarily superior. Some prevention strategies with the strongest theoretical rationale – e.g. community development and community mobilisation approaches, indigenous-led approaches or societal-level prevention – have not yet been subject to sufficient evaluation (VicHealth 2007). Though not yet assessed as effective, such strategies may in fact hold the best potential for reducing violence at a population level.

Conversely, other interventions, e.g. some US-based school prevention programmes, have been evaluated extensively and assessed as successful (World Health Organization and London School of Hygiene and Tropical Medicine2010, World Health Organization 2002), but this could be due – at least partially – to their widespread use (VicHealth 2007).

This review identifies examples of interventions with evidence of proven effectiveness, but also discusses promising examples. These are not yet rigorously evaluated but are backed by either a sound theoretical rationale or evidence of implementation (e.g. process evaluation, strong community endorsement, addressing known risk and protective factors).

Outcomes of interest

This review sought evidence for a reduction in rates of intimate partner violence and elder abuse. As these ideal outcomes are under-researched, other related outcomes are included, e.g. reduced rates of youth violence, alcohol use, homicide rates, and child maltreatment; and improved attitudes toward gender equity and violence.

Relatively strong evidence exists on the primary prevention of youth violence and child maltreatment. The World Health Organization (2010) has argued this evidence may be applicable to the primary prevention of intimate partner violence and elder abuse. Diverse types of violence often share similar risk and protective factors (World Health Organization 2010).

The indigenous section (Section 5.3) takes a broader interpretation of potentially 'effective' outcomes, e.g. evidence of greater involvement of indigenous people in prevention strategies, increased trust or collaboration with services, or increases in empowerment or community connectedness. Much less evaluation has taken place on indigenous programmes, compared with generic literature. However, these broader outcomes may also be relevant for non-indigenous populations.

Reporting rates affect the measurement of effectiveness. For intimate partner violence and elder abuse, rates of reporting are often low. Estimating the impact of prevention on sexual violence is especially challenging as sexual violence is greatly under-reported and prosecuted at lower rates than other forms of violence (Casey and Lindhorst 2009). Increases in reporting rates are sometimes viewed as signs of success in this field, as possible indications of improved access to services.

Desired outcomes in this area are often long-term. At this stage, very few primary prevention programmes have been sustained or evaluated for enough time to assess longer-term impacts.

1.5   Review scope

This review answers three questions:

1.   What recent shifts in thinking have taken place on *why* primary prevention approaches are effective or promising?

2.   What evidence exists on the effectiveness of primary prevention of intimate partner violence and elder abuse? (including examples of programmes with known or emerging effectiveness and promising practices)

3.   What are common elements of effective primary prevention programmes (i.e. success factors)?

We focus particularly on indigenous prevention, children and young people, alcohol-related strategies, and community-level prevention, as requested. The review is largely on what works, rather than what doesn't work.

Our review synthesises recent literature reviews since 2006. It is not a comprehensive or systematic review. Though largely a 'review of reviews', we included some individual papers on promising interventions in New Zealand. The date limit was not applied to New Zealand literature. We do not aim to give exhaustive coverage of promising interventions, rather we provide selected examples.

Importance of 'upstream' prevention strategies

The literature contains more information on discrete programmes than on broader prevention strategies at a societal level. Less evaluation exists on 'upstream' primary prevention strategies like improving material conditions, access to education, employment opportunities, and reducing income inequality.

It is vital that a comprehensive approach to primary prevention includes and prioritises actions at the societal or macro level, as this is likely to achieve the greatest gains on a population level (Bellis et al 2012, World Health Organization 2010, VicHealth 2007).

Exclusions from this review

As noted, material on the prevention of child maltreatment – as well as prevention using school-based or parenting support programmes – was excluded. Evidence from developing countries was also excluded, as the intention is to learn from countries similar to New Zealand. The review is not a stocktake of current primary prevention activities and gaps across New Zealand, nor does it analyse the cost-effectiveness of programmes.

Review method

The work took place in May and June 2013. After a scoping stage in consultation with the Ministry of Social Development (MSD), we selected papers for inclusion, drawing mostly on a set of recommended reports and papers provided by MSD. We supplemented this with additional searching of academic databases (e.g. PsycINFO, Medline, Scopus, Social Science Citation Index), using the Medical Library at the University of Otago, Wellington. As well as searching academic databases, we searched the Internet using Google Scholar, and hand-searched selected relevant websites. All potentially relevant papers, articles, and reports were assessed for inclusion, using agreed selection criteria. We then reviewed and summarised the set of included papers, and wrote the findings into narrative form in this report.

1.6   Strengths and limitations of this review

Key strengths of our review are:

- The synthesis of a broad range of recent literature on primary prevention (2006-2013).
- The review has a focus on indigenous-led and community-based prevention, as well as on child- and youth-focused interventions.
- Associate Professor Janet Fanslow, an Auckland-based academic expert in family violence, peer reviewed the draft report. As well, a range of policy experts provided review comments on the

draft report. They were in various government agencies including the Ministry of Social Development and Ministry of Women's Affairs.

Limitations include:

- The rapid scope and short timeframe mean our review gives only a broad-brush overview of a wide range of prevention strategies and examples.

- As our review drew mostly on existing reviews and literature syntheses, it relies on the quality assessment and interpretation of other reviewers. However, reviews by leading experts and reputable academics were selected.

- Most of the published evaluation literature is from the US and prevention programmes may not transfer easily to other contexts (World Health Organization and London School of Hygiene and Tropical Medicine 2010). New Zealand's cultural and social structures are different to the US, although the dynamics of intimate partner violence and elder abuse are generally similar (this is discussed more in Section 4.4).

- The New Zealand examples are drawn from a selected set of papers, mostly from within other reviews supplemented by limited searching for individual evaluations. Hence the information is incomplete and we may have missed some crucial promising programmes.

- The overlap between the three types of prevention (primary, secondary, tertiary), noted earlier, is reflected in the literature reviewed. Some reviews did not give enough detail to be able to assess the degree to which particular interventions were primary or secondary prevention. In some cases, prevention programmes themselves operated at both levels.

- Some researchers recommend learning from other primary prevention fields where community and societal-level risk factors are more established, e.g. the primary prevention of youth violence, sexual health, HIV, and alcohol misuse. We were not able to consider these areas in detail, aside from alcohol misuse (see Section 5.4), because of the short timeframe.

- We have not sought literature on particular population groups (aside from Māori and Pacific peoples), e.g. people with disabilities, migrant and refugee communities or rural populations, because of the tight scope.

2 Why we need to prevent violence before it occurs

This section provides a rationale for why we should prioritise the primary prevention of violence, including partner and elder abuse. It gives a brief picture of the extent and impact of these forms of violence in New Zealand.

Past years have seen a long history of activism on violence against women, led by the women's movement. Violence, including intimate partner violence and elder abuse, is now widely recognised as a global public health concern and a fundamental violation of human rights (World Health Organization 2013 and 2010, Bellis et al 2012, Fanslow et al 2010, VicHealth 2007).

Experts agree it is vital to work towards the primary prevention of violence – as it is prevalent, serious, and wholly preventable (World Health Organization 2013, World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007).

Because of the serious harm and on-going effects from violence across the lifespan, preventing violence before it occurs – primary prevention – will save both lives and money (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Extent and impacts of intimate partner violence in New Zealand

Intimate partner violence is an immense and serious problem in New Zealand. As data is available elsewhere (e.g. New Zealand Family Violence Clearinghouse), we give only a snapshot here.

It is estimated that 1 in 3 women in New Zealand have been the victim of physical and/or sexual intimate partner violence in their lifetime (Fanslow and Robinson 2004, cited in Point Research 2010). There are stark inequalities across ethnic groups. Prevalence for Māori and Pacific populations is discussed below.

Prevalence figures are even higher if psychological abuse is included. A 2011 study found that 55% of women had experienced intimate partner violence, including psychological abuse, in their lifetime. Around a third had experienced more than one type of violence – usually psychological/emotional violence and physical and/or sexual violence (Fanslow and Robinson 2011).

These figures are consistent with other countries. The first comprehensive systematic review of global prevalence has found that, worldwide, 30% of women have experienced intimate partner violence. When non-partner violence is included, e.g. physical or sexual violence from strangers, the figure rises to 35% (World Health Organization 2013).

US research suggests that homosexual and bisexual men and women experience rates of intimate partner violence at least as high, and often much higher, than heterosexuals (Walters 2013), although earlier international studies suggested similar rates (Lievore and Mayhew 2007). This area is under-researched in New Zealand and requires more attention (Lievore and Mayhew 2007).

As noted, widespread under-reporting of violence is likely, especially for sexual violence and elder abuse (Quadara and Wall 2012, Daly et al 2011, Casey and Lindhorst 2009). Drawing on a representative survey of New Zealand women, Fanslow and Robinson (2010) reported that only 12.8% of women spoke to the police about violence they experienced.

Impacts of intimate partner violence

Significant, long-term harm can result from violence victimisation, including serious adverse consequences for physical and mental health, education, and employment. Major impacts on health, assessed by the World Health Organization's 2013 global report, include death, injury, depression, alcohol use problems, sexually transmitted infections, and adverse effects on mental health and social functioning.

The harm caused may last a lifetime and span generations (World Health Organization and London School of Hygiene and Tropical Medicine 2010). The devastating effects of violence do not just affect individuals, but families, whānau, workplaces, communities, and our economy.

Māori prevalence

Though all ethnic groups in New Zealand have high rates of intimate partner violence, Māori are "substantially over-represented" as both victims and perpetrators of whānau violence (Te Puni Kōkiri

2009). Lifetime prevalence of physical and/or sexual partner violence is more than one in two (57.6%) for Māori women, compared with one in three for European/other (34.3%). For 12-month prevalence, the rate for Māori women is more than twice that for European women (Fanslow et al 2010).

These findings align with indigenous populations in other countries (Cooper 2012, VicHealth 2007). Approaches to prevention need to acknowledge that Māori have not been well served by previous interventions and current efforts to address violence.

Cultural and historical factors affect violence

Indigenous literature from New Zealand and overseas agrees that strategies to prevent indigenous family violence must consider the historical and contemporary contexts of indigenous communities (Cooper 2012, Shea et al 2010, VicHealth 2007, Kruger et al 2004). This includes acknowledging and addressing the impacts of structural factors, especially colonisation and racism, on indigenous people today.

In New Zealand, the processes of historical colonisation eroded Māori self-determination and control, and contributed to the loss of land, language, values, beliefs, and practices. This has resulted in enduring experiences of disadvantage, racism, and marginalisation, which are understood to contribute to an intergenerational cycle of violence (Cooper 2012). The current social picture for Māori at least partially reflects the trauma of colonisation transmitted through generations, as for overseas indigenous groups (Cooper 2012, Shea et al 2010, VicHealth 2007, Kruger et al 2004).

The contemporary impacts of colonisation and racism interact with a wide range of other contributors to indigenous family violence, such as low socioeconomic status and poverty, and high rates of alcohol and substance use (Shea et al 2010, Te Puni Kōkiri 2010, Memmott et al 2006).

Pacific prevalence of violence

Research suggests that intimate partner violence is common in Pacific communities (Percival et al 2010). Although lifetime prevalence of physical and/or sexual partner violence for Pacific women (32%) is similar to European/other women (34%), the 12-month prevalence rate is more than twice as high (Fanslow et al 2010).

Pacific peoples represent youthful and growing populations. Predictions are that in 15-20 years, 1 in 5 New Zealand children will be of a Pacific ethnicity (Siataga 2011).

It is important to recognise that Pacific groups are not a homogenous population – there are more than 20 distinct Pacific ethnicities in New Zealand. Pacific literature consistently highlights the need to consider this heterogeneity. Pacific populations represent a range of peoples who align themselves variously, and at different times, along ethnic, geographic, church, and family lines.

Extent of elder abuse in New Zealand

Early evidence indicates that elder abuse and neglect likely occurs across all social, economic and ethnic groups and is under-reported. This may be because of a lack of awareness and poor detection, or a degree of reluctance to report suspected cases where it is recognised (Lievore and Mayhew 2007).

Prevalence data is scarce, but the problem is thought to be significant. New Zealand literature in 2007 estimated that approximately two to 10% of older people have experienced possible elder abuse or

neglect (Lievore and Mayhew 2007), which in 2007 translated to between 10,000 and 50,000 older people aged 65 years and over (Lievore and Mayhew 2007). In light of the ageing population in New Zealand, elder abuse is predicted to increase in future.

Based on available evidence, Māori rates of elder abuse do not appear to be disproportionately high – 11% of elder abuse victims in 2006 were Māori. This likely reflects the lower life expectancy of Māori (Cooper 2012).

Economic cost of violence

Researchers argue the financial costs of prevention need to be weighed against the extremely high social and economic costs of current violence levels. In the US, the victim costs from sexual violence is estimated at $126 billion annually (DeGue et al 2012a).

The costs of violence in New Zealand are currently being estimated. We know that sexual violence is the *most costly* crime per incident in New Zealand (Ministry of Justice 2009, cited in Dickson 2013).

Internationally, there is growing consensus that we cannot afford *not* to fund primary prevention, given the high extent and significant harm and costs of violence.

3   Latest thinking on what works in primary prevention

This section discusses key shifts and current thought on the broad principles and approaches considered to have the most promise in preventing violence before it occurs.

3.1   Understanding violence and what affects it

Since the 1970s, theoretical understandings of violence have shifted from explanations centred on individual biology and pathology to broader social theories like feminist analyses based on gender or the effects of alcohol and drug use. However, single-factor analyses were criticised for being narrow and insufficient.

The last decade has seen wide recognition of the multiple, inter-related causes of violence (World Health Organization 2010, World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007, World Health Organization 2002).

Reflecting the gendered patterns of violence, gender inequality and socialisation into rigid gender roles are seen as core underlying influences on perpetration (VicHealth 2007). Feminist analysis continues to be influential in understandings of violence, along with more recently-developed human rights frameworks.

Indigenous perspectives and theories on violence are important for informing prevention. The Mauri Ora conceptual framework, discussed later, is an example of a Māori perspective on violence. The Māori Taskforce on Whānau Violence (Kruger et al 2004) developed the framework, which is widely supported in Māori literature (Cooper 2012).

3.2   Shift to primary prevention

In the past decade, the violence field has shifted to prioritise primary prevention. Violence is now widely recognised as a global public health problem (Bellis et al 2012, DeGue et al 2012b, World Health

Organization and London School of Hygiene and Tropical Medicine 2010, Carmody et al 2009, VicHealth 2007). Primary prevention requires changing the underlying conditions in families, communities, and society that allow intimate partner violence and elder abuse to happen.

Broad agreement exists across sectors and disciplines that primary prevention is desirable (Quadara and Wall 2012). The high rates of intimate partner violence mean that it is challenging and costly to provide services for all of those affected. It is also difficult to change behaviours and patterns once established, so preventing violence in the first place is understandably desired.

International bodies like the World Health Organization and the US-based Centers for Disease Control and Prevention (CDC) were instrumental in calling for this shift, supported by practitioners and researchers (McMahon et al 2011). A public health approach is consistent with and builds upon feminist and human rights-based approaches (World Health Organization 2002).

New Zealand is seeing a corresponding shift, with much work underway that aims to prevent violence from occurring in the first place, e.g. community action initiatives around the country, and more learning about works in primary prevention (e.g. Ministry of Social Development 2011).

There is also increasing optimism that violence can be prevented (Bellis et al 2012, VicHealth 2007). A seminal report by Australia's VicHealth (2007) stated: "The prevention of violence against women is not an aspirational goal, rather, it is well within our reach" (VicHealth 2007, p.5).

Limitations of a public health approach

It should be noted that public health perspectives have been developed in a western context and from a western standpoint. A public health framework is not necessarily appropriate for Māori and other ethnic groups (Ministry of Women's Affairs, forthcoming a). A deeper understanding of what primary prevention means for Māori, and other groups, is needed.

A limitation of the public health approach is that monitoring the impacts of primary prevention can be challenging. Interpersonal violence also differs from other health issues in its nature and impact, e.g. it is a crime and an abuse of human rights (Ministry of Women's Affairs, forthcoming a), so may require additional strategies for prevention.

3.3　Working across sectors and ecological levels

In line with a public health perspective, the violence prevention field is increasingly taking an ecological, cross-sectoral approach to primary prevention (Cooper 2012, VicHealth 2007). The ecological approach is applied to help understand and theorise about the multiple causes of violence, as well as to inform primary prevention.

As depicted in the illustration below, influences on violent behaviour or vulnerability to violence lie at multiple and interacting levels: individual, relationship, community, and societal (DeGue et al 2012a, Quadara and Wall 2012, VicHealth 2007). This understanding reflects the complex mix of personal, social, and cultural factors that contribute to violence.
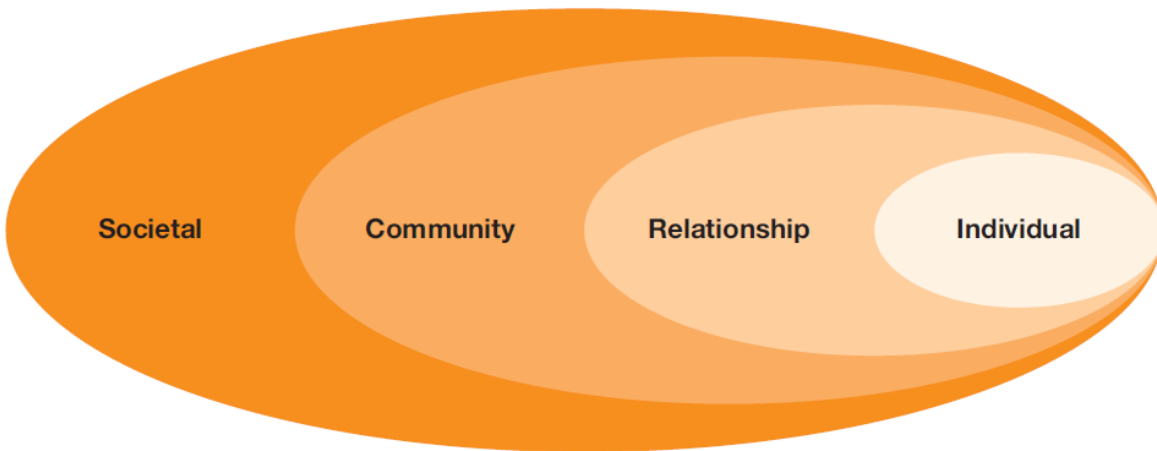
Figure 1: The ecological model for understanding violence. Source: World Health Organisation. *World report on violence and health*. WHO: Geneva, 2002.

Programmes that aim to prevent intimate partner and sexual violence are increasingly adopting an ecological approach, e.g. whole-of-school violence prevention programmes, whole-of-community interventions, and multi-level social marketing approaches (Carmody et al 2009). The ecological model has been applied successfully in other fields, e.g. in the prevention of HIV, bullying, drunk-driving, adolescent tobacco use, and community violence (Casey and Lindhorst 2009).

Need for community and societal change

The ecological model highlights that primary prevention must tackle the complex social issues that allow intimate partner violence to be perpetrated. It acknowledges that environmental-level change is needed to enable and support individual efforts to change (Bellis et al 2012, DeGue et al 2012b, World Health Organization and London School of Hygiene and Tropical Medicine 2010).

The latest thinking in violence prevention[2] suggests that we need preventive strategies at all four levels, but that community and societal levels are especially vital – because there is greater potential for change at these broader levels of influence (Quadara and Wall 2012, Casey and Lindhorst 2009). Some researchers argue that individual level approaches are unlikely to reduce rates of violence because changes in individual behaviour are harder to sustain in an environment that supports a violent, sexist culture (Quadara and Wall 2012, Casey and Lindhorst 2009).

However, almost all evaluated prevention programmes focus on changing individual or family-level attitudes and behaviours. Far less evaluation has taken place on prevention strategies at the community level (Casey and Lindhorst 2009, Fanslow 2005). This is probably because individual interventions are more straightforward to implement and evaluate, compared with complex, multi-level community-based interventions or universal policies.

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[2] e.g. from leading organisations like the US Centers for Disease Control and Prevention (CDC) and the Prevention Institute

Cross-sector approach

Community and societal change requires a multi-agency, cross-sectoral approach. Connections between Māori organisations and representatives, public health, local authorities, children's and youth services, older people's organisations and services, education services, community safety, and alcohol licensing are needed, for example (Bellis et al 2012).

In a 2005 report for the Families Commission, Beyond Zero Tolerance, Janet Fanslow promoted the integration of the ecological model and coordinated, multi-sector responses – see diagram below. The diagram illustrates that all sectors have influence and responsibilities across all ecological levels, as well as interactions and links with other sectors (Fanslow 2005). Applying a cross-sector approach means that consistent messages promoting non-violence will come from multiple places and reinforce each other.

Diagram showing the integration of ecological and cross-sector models (Fanslow 2005):
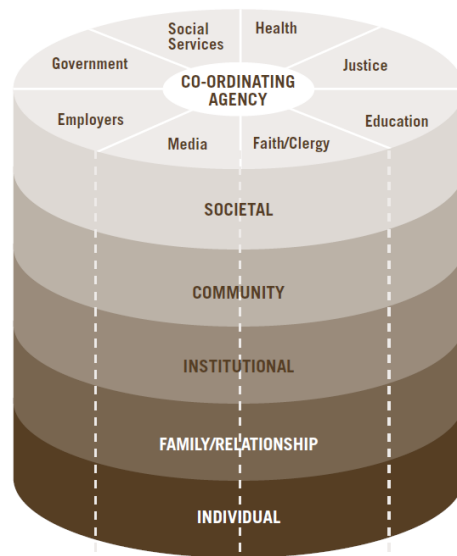
Reducing inequalities

Societal-level prevention should also focus on reducing socio-economic inequalities, because differences in general violence levels experienced in the most affluent and most deprived communities are stark (Bellis et al 2012). UK research estimates that people in deprived communities are five times more likely to be victims of general violence (Bellis et al 2012).

The New Zealand prevalence data for intimate partner violence shows differential rates between ethnic groups, e.g. Māori and Pacific women are over-represented as victims (Fanslow et al 2010). At the same time, intimate partner violence is known to occur in all ethnic groups and income brackets.

3.4 The need for a life-course perspective

A life-course perspective is widely endorsed in prevention research and practice (Bellis et al 2012, Gluckman 2011, World Health Organization 2010, VicHealth 2007). It acknowledges that infant and early childhood experiences greatly influence the likelihood of later becoming a perpetrator or victim of

partner and sexual violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

A life-course perspective points to a focus on children and adolescents. Early intervention to change behaviour is backed by strong evidence across a number of fields (Bellis et al 2012, VicHealth 2007). This suggests opportunities for providing age-appropriate programmes to develop healthy and respectful relationship skills, and other life skills, throughout early childhood and school settings.

Adolescence is the optimal timing for preventing *sexual* violence because it is when sexual aggression tends to emerge, alongside the escalating influence of peers and social norms (Casey and Lindhorst 2009). So prevention with adolescents may have a greater impact than with other ages.

However, a life-course perspective also suggests a need for primary prevention with older age-groups. Since violence occurs across the life cycle, 'whole of population' approaches must be designed to reach older men and women as well as younger age-groups (VicHealth 2007).

3.5   Strengths-based, positive approaches

Strengths-based approaches to primary prevention are increasingly favoured over deficit or risk-based models. In Australian sexual violence prevention education, for example, a major shift has occurred from risk avoidance to promoting positive, ethical sexualities and positive gender norms through universal school-based prevention and positive sexuality work with young adults (Carmody et al 2009). A more positive approach to family violence prevention can also be seen in New Zealand, e.g. the Māori taskforce's work on transforming whānau violence (Kruger et al 2004) and the approach taken in our 'It's Not OK' campaign, discussed later (Ministry of Social Development 2011).

In the past two decades, the elder abuse field has shifted emphasis from protection to the empowerment of older people. This drew from the fields of intimate partner violence and rights-based approaches; recognising the rights of elders, including those with diminished capacity, to live free of abuse, neglect, and exploitation (Bagshaw et al 2009). Recent literature on elder abuse pays more attention to the power and control dynamics in abusive relationships, and the social, economic, and cultural barriers that some victims face (Bagshaw et al 2009).

The public health approach has traditionally focused on risk factors and problem-solving and this may still persist to a degree. However, much public health literature increasingly highlights protective factors associated with violence, e.g. community involvement/connectedness, supportive parenting, education, employment and financial security, and personal resilience (Bellis et al 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007).

Positive youth development

Youth development approaches draw on evidence showing that the same risk and protective factors affect wide-ranging outcomes for young people, including violence (Boyd and Barwick 2011). Positive youth development is consistent with the New Zealand Youth Development Strategy. Instead of focusing exclusively on the prevention of violence, positive youth development programmes target various youth problems by attempting to enhance shared protective factors, e.g. social and emotional skills, thereby preventing or reducing a range of negative outcomes like substance misuse, sexual risk-taking, and violence. Literature suggests that positive youth development promotes competence (socially, emotionally, cognitively and behaviourally) and develops resilience, self-determination, identity, and pro-social norms (Boyd and Barwick 2011).

US evaluations indicate that positive youth development interventions have achieved significant improvements in problem behaviours (Boyd and Barwick 2011, Whitaker and Reese 2007). Though we lack literature on positive youth development in relation to Māori and Pacific youth, the approach aligns with whānau ora and Pacific models of health.

3.6 Targeting men and boys in violence prevention

A greater focus on men and boys – and a move from victims to targeting perpetrators – has developed in the past decade. This shift is consistent with indigenous approaches that highlight the integral role of perpetrators within an extended family/whānau and community context (Cooper 2012).

Traditionally, prevention efforts were aimed at changing women's behaviour as potential victims, e.g. rape avoidance or resistance strategies (Carmody et al 2009, VicHealth 2007). Evidence shows that victim-focused strategies have limited impact (DeGue et al 2012b). Reducing perpetration and addressing violence-supportive social norms is more likely to achieve population-level reductions in violence.

Examples, discussed later, include delivering prevention in settings relevant to men like some sports environments (e.g. using sports heroes as positive role models for anti-violence campaigns), active bystander approaches, and challenging the gender norm of 'hyper-masculinity', which is associated with the perpetration of violence (DeGue 2012a and b, Carmody et al 2009, Robertson and Oulton 2008).

4 How much evidence is available?

This section considers the overall state of evidence, while the next section gives detail on each of the five interventions in this review (including examples of effective and promising programmes).

4.1 Intimate partner violence

In 2010 the World Health Organization concluded that the field of intimate partner and sexual violence prevention was "at its earliest stages" toward an established evidence base for primary prevention strategies, programmes, and policies (World Health Organization 2010). More recent literature agrees the evidence base is limited and still emerging (Leen et al 2013, Bellis 2012). This does not mean that prevention is ineffective; rather it has not yet been sufficiently evaluated.

The literature on sexual violence prevention is especially limited. Many existing prevention approaches, focused mostly on individuals, have shown only small or short-lived effects (Quadara and Wall 2012). However, an emerging set of studies have shown promise in changing longer-term rates of sexual violence perpetration (Quadara and Wall 2012, Casey and Lindhorst 2009).

Although evaluated prevention is scarce and findings on effectiveness are not clear-cut (Leen et al 2013, Fanslow 2005), practitioners in gender-based violence fields have been working to develop prevention programmes based on best practice principles (Casey and Lindhorst 2009) and a large amount of work is underway (Bellis et al 2012, World Health Organization 2010, VicHealth 2007, Fanslow 2005).

Risk and protective factors for partner and sexual violence

International evidence presents various known risk (and protective) factors for intimate partner and sexual violence. Risk factors include: female gender, younger age, lower household income, alcohol consumption (both perpetrators and victims), controlling and jealous partner, a history of childhood

maltreatment (both perpetrators and victims), gender inequality, and cultural norms tolerant of violence (Bellis et al 2012).

Protective factors include: education (secondary schooling or higher, for both perpetrators and victims); having benefited from positive parenting in childhood; having a supportive family; living within an extended family structure – of particular relevance in Māori and Pacific communities in New Zealand; and community involvement/connectedness (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Effectiveness of school-based and family support programmes

As noted, this review focuses on five selected intervention approaches, discussed next. Two intervention types that are excluded from our review – school-based programmes and family/parenting support interventions – are supported by evidence of effectiveness for many programmes (Bellis et al 2012, World Health Organization 2010, World Health Organization and London School of Hygiene and Tropical Medicine 2010, Bilukha et al 2005). This detail is not covered here because it is canvassed by other projects underway in New Zealand – led by the Ministry of Women's Affairs, Ministry of Education, and the Families Commission.

It is important to note, though, that some of the best available evidence is in these two areas. Some US-based school-based preventive programmes have been evaluated extensively and assessed as successful (e.g. World Health Organization 2010, World Health Organization and London School of Hygiene and Tropical Medicine 2010), especially whole-of-school approaches (Carmody et al 2009). School-based programmes are "well supported by evidence" in preventing IPV, and there is "emerging evidence" for sexual violence prevention, according to the World Health Organization (2010).

Prevention programmes known to be ineffective

The literature suggests that prevention programmes which simply aim to change knowledge or awareness without any attempts to change attitudes, behaviour or social norms are likely to be ineffective in preventing violence (Leen et al 2013).

Short-term media campaigns that are implemented in isolation, without a comprehensive social marketing approach, are also likely to fail to reduce or prevent violent behaviour (Bellis et al 2012, VicHealth 2007). Generally, one-off interventions are thought to have less chance of success than repeated, sustained interventions.

4.2   Elder abuse

Elder abuse is a largely hidden form of violence, although awareness has risen in recent decades (Bellis et al 2012). Globally, there exists an extremely limited amount of evaluated prevention strategies and little understanding of risk and protective factors (Norris et al 2013, Daly et al 2011, World Health Organization 2010, Bagshaw et al 2009). Compared with the prevention of other types of family violence, it is under-researched, under-reported, and under-funded (Sibbald and Holroyd-Leduc 2012, Daly et al 2011). The research gap is attributed to a lack of consensus on definitions and causes, and fragmented research and practice (Norris et al 2013). The family violence field has tended to focus on younger women and children, although evidence shows that violence affects older women as well (Lievore and Mayhew 2007).

The current literature consists mainly of descriptive, observational case studies, no meta-analyses and a small number of intervention trials (Daly et al 2011). A few intervention trials have been conducted in health care settings, aiming to reduce abuse by health care professionals while at work (so not in a family context), with success demonstrated in most studies (Daly et al 2011).

Promising approaches

Nonetheless, we know that the problem is large with serious consequences, so it is important to implement – and evaluate – multi-disciplinary prevention strategies (World Health Organization undated, Fanslow 2005). Effective and promising approaches in the family violence field may transfer well to elder abuse, e.g. community development approaches (Norris et al 2013).

Community and societal interventions to address ageism and alcohol

At a societal level, addressing ageism is seen as vital in preventing elder abuse, e.g. transformative approaches that critique the social, political, cultural, economic, ethnic, and gender structures that constrain and exploit people (Norris et al 2013, Bagshaw et al 2009). Participatory and empowerment (i.e. community development) models are thought to hold the most potential to address the ageist context in which abuse occurs, allowing older people to develop their own prevention approaches instead of relying on professional expertise (Bagshaw et al 2009). However, more support and capacity-building is likely to be needed for this to happen.

As research (e.g. Homer and Gilleard 1990, Chow and Mayer 2000, cited in World Health Organization undated) has identified harmful and hazardous alcohol use as a major risk factor for elder abuse, strategies to reduce alcohol-related harm are important, e.g. promoting prevention and early intervention in alcohol problems in primary health care (World Health Organization undated). The World Health Organization states that a key factor in primary prevention is the identification of older people at risk of being abused (World Health Organization undated), suggesting a need for screening programmes in health services (which usually address secondary prevention but can also be used for primary prevention to identify those at risk, before violence has occurred).

Researchers say it is especially vital to train professionals in the recognition of and responses to the signs of abuse in later life, as things like social withdrawal can be misinterpreted as a 'normal' part of the ageing process (World Health Organization undated). New Zealand's Ministry of Health has produced national guidelines to assist health care providers with this[3], however implementation has not been systematically supported[4]. Other researchers support the need for training a range of service providers (e.g. police, carers, household help, faith leaders) to be able to identify abuse and people at risk of abuse (Bagshaw et al 2009).

Family-focused prevention

Family-focused prevention work is underway in Australia, using older-person-centred family mediation to prevent the financial abuse of older people by family members. This is thought to help families to become more resilient. Researchers say that such mediation needs to be voluntary and older-person-centred (Bagshaw et al 2009).

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[3] http://www.health.govt.nz/publication/family-violence-intervention-guidelines-elder-abuse-and-neglect
[4] Personal communication, Janet Fanslow, University of Auckland School of Population Health, 19 June 2013.

Some researchers argue for preventive measures to reduce the stress of caregiving, e.g. respite care and financial support for caregivers, which currently happens in Australia and Germany (Sibbald and Holroyd-Leduc 2012). Respite programmes provide care for dependent older people to give caregivers a break. Some research shows day-care for older people can reduce perceptions of caregiver burden, and depression and anger, however more research is needed to identify its impact on elder abuse (Bagshaw et al 2009). Other measures to support caregivers, to potentially prevent elder abuse, are improving services for both carers and those being cared for and support groups for carers (Sibbald and Holroyd-Leduc 2012).

Researchers stress that reducing caregiver stress is not the only answer, though, as other risk factors are involved, e.g. social isolation and lack of social support, age discrimination, and alcohol and drug misuse by caregivers (Bellis et al 2012, Lievore and Mayhew 2007). There is also a need to address continuing patterns of intergenerational violence, e.g. \ violence between partners, or child-to-parent violence that was previously parent-to-child.

Collaboration between domestic violence and ageing sectors

Because of the complexity of elder abuse, researchers advocate more dialogue and learning between the domestic violence sector and the ageing sector – both practitioners and researchers. Approaches to research, definitions, and intervention can differ markedly and lead to inadequate and inconsistent responses (Bagshaw et al 2009).

Culturally diverse interventions

The literature on elder abuse also indicates a need to develop culturally-specific responses for older people in indigenous and culturally and linguistically diverse (CALD) communities (Bagshaw et al 2009).

4.3 The need for integrated approaches

Prevention researchers criticise the lack of coordination, at both practice and research levels, between child maltreatment, alcohol and substance misuse, social determinants (e.g. housing, transport, education), and intimate partner and sexual violence. Yet all of these problems regularly affect families, especially the economically-disadvantaged (World Health Organization and London School of Hygiene and Tropical Medicine 2010, World Health Organization 2002).

Indigenous experts, too, have critiqued the 'siloing' of the interlinked problems of family violence (Victoria Department of Human Services 2012, VicHealth 2007). They argue for the integration of various forms of violence, as well as addressing structural issues of colonisation, poverty, and racism as part of family and whānau violence prevention.

Hence, prevention responses that address the links between different types of violence are needed (World Health Organization 2002). In particular, researchers recommend greater recognition of the links between intimate partner violence and child maltreatment (Murphy et al 2013a). They advise integrating elements of violence prevention programmes into programmes that address other issues. At the very least, there should be assessment and cross-referral between the agencies addressing these other problems.

Other countries, e.g. Australia and the UK, are increasingly adopting integrated strategies that address *all* forms of violence against women. This is seen as more effective because of the underlying

commonality of issues like gender roles and gender inequality to multiple forms of violence against women (Quadara and Wall 2012, Ministry of Women's Affairs, forthcoming a).

4.4   Adapting overseas programmes to the New Zealand context

North American programmes dominate the current prevention literature and may not be directly transferable to the New Zealand context (Robertson and Oulton 2008). Adaptation to our particular context is likely to be required. Still, North American programmes can provide a basic starting point, which may help to identify core elements for similar programmes here.

Overall, the literature seems to favour learning from the broad principles and approaches that are considered good practice, and to apply this general learning to local contexts.

5   What works to prevent partner and elder violence?

Complex problems like intimate partner violence and elder abuse require comprehensive and multi-faceted solutions (Norris et al 2013, Cooper 2012, Point Research 2010, Casey and Lindhorst 2009). Research shows multiple and varying pathways toward perpetration, suggesting a need for diversity in preventive approaches (Casey and Lindhorst 2009). This section discusses five types of interventions:

- societal-level approaches
- community-level approaches (e.g. community development, bystander and social marketing approaches)
- indigenous-led approaches
- approaches to reduce alcohol harm, and
- approaches targeting children and youth.

Each section introduces and defines the approach, and comments on the current level of supporting evidence. Examples are then given of evaluated and promising interventions from overseas, and in New Zealand where possible.

Note: Even for the approaches supported by rigorous evidence of effectiveness, this does not necessarily mean that *all* interventions using that approach will be effective. It just means there is existing evidence for some interventions using that approach. It is also important that effective and promising programmes are well implemented (i.e. programme fidelity) – and carefully monitored to ensure that they are implemented as intended.

5.1   Societal-level approaches

Approaches at the societal level – the outer rim of the ecological model – include policy and legislation, addressing gender discrimination, and changing social norms through initiatives such as social marketing and media advocacy (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Societal prevention often overlaps with the community level, as social norms can be addressed within communities as well. Community-level prevention, including social marketing, is discussed below.

Societal-level risk factors

The World Health Organization's 2002 international report on violence identified key community- and societal-level risk factors for sexual violence, based on extensive research across countries (both developed and developing countries). These include: poverty, societal acceptance of violence, lack of

accountability for perpetrators, and social norms that are patriarchal and rape-supporting (Casey and Lindhorst 2009).

Challenging gender inequality

Gender inequality is a key social norm that can be targeted by policies or legislation (Quadara and Wall 2012, Robertson and Oulton 2008, VicHealth 2007). As noted, it is known to be an underlying risk factor for intimate partner violence and elder abuse (Quadara and Wall 2012, VicHealth 2007).

State of evidence

Experts argue that community and societal-level approaches have strong potential for primary prevention at a population-level (Quadara and Wall 2012, Casey and Lindhorst 2009). Though considered the most challenging level for effecting change, the literature suggests it is possible to take steps toward societal level change. There are existing examples of this level of change (VicHealth 2012b, Casey and Lindhorst 2009).

However, current literature tends to focus more on community rather than societal level prevention, so much remains to be learned about effective primary prevention at a societal level (Quadara and Wall 2012, DeGue et al 2012a, World Health Organization and London School of Hygiene and Tropical Medicine 2010). The World Health Organization recommends greater evaluation of policies for their effects on rates of violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

In their review, DeGue and colleagues (2012a) found only one formal evaluation of a specific intervention at the societal level. That evaluation assessed the effectiveness of funding provided by the US Violence Against Women Act (VAWA) on violent crime including rape. Findings show that VAWA grants were associated with reductions in rape and assault (Boba and Lilley 2009). These relationships persisted after controlling for general downward crime trends and the effects of other justice grants. The researchers noted that the results support continuation of this funding stream (Boba and Lilley 2009).

The Prevention Institute in the US has developed a multi-level approach which explicitly addresses the societal level alongside actions at the other levels of the ecological model. The Spectrum of Prevention tool has six layers, including fostering coalitions and networks, changing organisational practices, and influencing policy and legislation. Spectrum strategies have been applied in communities throughout the US to a variety of issues, e.g. traffic safety, nutrition, physical activity, and violence prevention. However, our review did not find any published evaluation of effectiveness in preventing intimate partner violence.

Media advocacy

Media advocacy is a promising strategy because the media is a lens through which the public views family violence (Point Research 2010). Reporters can and do influence the way people think and act. Changes to media regulations to reduce the level of violence displayed is considered a likely effective approach, alongside structural and policy approaches to strengthen gender equality (National Council to Reduce Violence against Women and their Children 2009). Working with media organisations to improve media treatment of sexual violence, and advocating to media outlets to decline to accept advertising

which includes demeaning portrayals of women, is also considered promising (Robertson and Oulton 2008).

Social and economic development

General improvements to social and economic conditions may potentially help to reduce intimate partner violence and elder abuse (Bellis et al 2012, Robertson and Oulton 2008). This is because of the close association with macro-level factors like unemployment, income inequality, and access to education (World Health Organization 2010). Policies to strengthen indigenous and other cultural communities, e.g. economic development policies to strengthen the economic base of Māori communities, are likely to help prevent family violence (Clark 2004, cited in Robertson and Oulton 2008). Other societal-level targets include policies on male and female patterns of employment; income levels; and women's access to health care, education, and political representation (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Next, we briefly summarise several examples of societal-level prevention, first evaluated examples and then promising.

Evaluated examples of societal-level prevention

- **Minimum purchase age policies** for purchasing alcohol are well supported by evidence of effectiveness in reducing the general harms caused by alcohol, so may potentially reduce intimate partner and elder violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

- **Banning alcohol advertising** is considered effective in reducing general harm from alcohol, based on strong longitudinal evidence for the effects of alcohol marketing on youth initiation of drinking and hazardous drinking behaviour (Braaf 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010). However, there is limited research on the impact of alcohol advertising on the general population's alcohol consumption, and on the effectiveness of alcohol advertising restrictions (Braaf 2012).

Promising examples of societal-level prevention

- The **Respect, Responsibility and Equality (RRE) program,** Australia (discussed more in the next section) encourages prevention at community and societal levels through developing policies and communicating messages about gender equality and non-violence across organisations, building organisational and workforce capacity for community-based initiatives, and supporting advocacy for cultural change and policy reform (VicHealth 2012b).

- **Restrictions on the sale and supply of alcohol** have been introduced in a number of Aboriginal and Torres Strait Islander communities, with evaluations mostly positive, e.g. Tennant Creek in the Northern Territory tried various alcohol restrictions and achieved sizeable reductions in per capita consumption of alcohol and declines in hospital admissions over 1 to 2 years after the restrictions came in (Braaf 2012).

- The **Coaching Boys into Men media campaign**, US, was funded by the Family Violence Prevention Fund and aims to provide adult men with skills for challenging gender stereotypes and violence-supportive norms and behaviours within peer networks, and among boys and

younger men. No experimental evaluations are available yet, but the campaign is thought promising (Casey and Lindhorst 2009).

- In New Zealand, media advocacy work at the societal level by the **It's Not OK campaign** has been praised by evaluation participants as "ground-breaking" (Point Research 2010). The campaign worked with the media to develop best-practice guidelines for accurate reporting, provided training for student journalists and newsroom reporters, and trained community spokespeople on getting messages into local community media (Ministry of Social Development 2011). This campaign is discussed more fully in the next section.

SUMMARY OF SOCIETAL-LEVEL INTERVENTIONS:

Societal-level approaches include strategies to change social norms and to address gender discrimination. This may use policy, legislation, and media advocacy, as well as community-based approaches. More evaluation of societal-level approaches is advocated in the international literature, but experts argue that community and societal-level approaches have the greatest potential for population-level primary prevention.

Current examples with positive results show that steps can be taken toward societal change, e.g. US federal funding to prevent violence against women, media advocacy, and changing the minimum purchase age for alcohol. A range of promising examples also exist, e.g. Australia's Respect, Responsibility and Equality programme and media campaigns focused on men and boys.

5.2   Community-level approaches

Community-level approaches are defined here as those which aim to change the characteristics of community-based settings – e.g. schools, workplaces, neighbourhoods – which influence violence (DeGue et al 2012a, Quadara and Wall 2012). Community-level strategies aim to shift social norms on violence, sexual behaviour, and masculinity in ways that may support individual-level changes in attitudes and behaviour. This section covers:

- Community development and community mobilisation

- Bystander interventions

- Working with men and boys to change social and gender norms

- Community social norms programmes and social marketing

- Settings approaches to change social and gender norms

- Partnerships/coordinated community interventions.

State of evidence

Evidence on primary prevention at a community level is still developing (DeGue et al 2012a, Quadara and Wall 2012, Casey and Lindhorst 2009). Nonetheless, the World Health Organization argues that community-level interventions can beneficially alter community-level characteristics and warrant more evaluation (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

The community-level is important in the ecological model, considered to have greater potential for preventing and reducing violence than individual and family interventions (DeGue et al 2012a, Casey and Lindhorst 2009). Early evidence supports the use of community-level strategies to change social norms and to promote gender equality[5] in particular (Bellis et al 2012, World Health Organization 2010, World Health Organization/London School of Hygiene and Tropical Medicine 2010).

Furthermore, the growing evidence in support of multi-level contributors to sexual violence (consistent with the ecological model), and the limitations of previous strategies in reducing sexual violence rates, points to a need to broaden prevention efforts to the level of communities and peer networks (Casey and Lindhorst 2009).

Community prevention of sexual violence

The sexual violence prevention literature, in particular, is dominated by research into individual approaches (DeGue et al 2012a, Casey and Lindhorst 2009). A recent systematic review found no evaluations of interventions directed at the community level, although some evaluated studies include community components as part of wider interventions (DeGue et al 2012a). Some researchers argue that much can be learned from successful primary prevention at community levels in other related fields, such as the prevention of HIV, bullying and community violence (Casey and Lindhorst 2009).

Community development and community mobilisation

A small body of literature is emerging on the effectiveness of community development and neighbourhood-level approaches (Sanders et al 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010, VicHealth 2007). Community development is defined as communities working together to identify their own needs and to create shared solutions to meet those needs. Community mobilisation and development approaches have also increased the effectiveness of universal communications or social marketing campaigns by reinforcing messages at the local level (VicHealth 2007). These approaches are supported by theory, promising viability and acceptability, and well-developed practice knowledge and skills (VicHealth 2007).

Family violence is affected by the presence or absence of community support and social networks, and community norms on violence (Sanders et al 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010, Point Research 2010, Mancini et al 2006). Increasingly, literature suggests that social networks have a key role in the perpetration of violence. Strong predictors of sexual assault perpetration include: involvement in social networks that hold rape-supporting norms; and peer approval of sexual force and coercion (Casey and Lindhorst 2009). Social cohesion among residents may also boost a community's capacity to manage crime and violence – e.g. by enhancing 'collective efficacy' – leading to reductions in intimate partner violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Increasing use of community development approaches

Community mobilisation and development approaches are increasingly being implemented in New Zealand, as in other countries. The US promotes community mobilization at a national level through the Centers for Disease Control and Prevention's DELTA project (Domestic Violence Prevention Enhancements and Leadership Through Alliances) project, with a strong focus on coordinated

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[5] *Gender equality* is defined as equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large (WHO 2010)

community responses (Shepard 2008). Also in the US, the Family Violence Prevention Fund and the Institute for Community Peace have completed broad initiatives to promote and support community engagement strategies to prevent violence.

Overseas examples of community development interventions

- **Community engagement violence prevention demonstration projects**, by the Institute for Community Peace in the US, have shown that community-based violence prevention resulted in measurable long-term reductions in homicide rates and improved policies and physical environments (Bowen et al 2004, cited in Casey and Lindhorst 2009).

- **Washington State in the US** has adopted a community development approach to the primary prevention of sexual assault (Casey and Lindhorst 2009). Services receiving federal Rape Prevention and Education funds are required to incorporate community engagement activities as part of their primary prevention efforts. Examples include: partnering with members of specific communities and community identification of needs (Casey and Lindhorst 2009). One non-experimental evaluation, of a community engagement approach with a residential substance abuse treatment community, showed self-reported improvements in knowledge about sexual violence, greater willingness to address sexual violence issues, and reductions in violence-supportive attitudes of residents and staff (Casey and Lindhorst 2009).

- **Elder Friendly Communities** are common public health approaches used in North America (at first in Calgary, Canada) to help older people to access social support in their communities. Elder-friendly communities aim to enhance quality of life, provide support, and encourage meaningful participation in local neighbourhoods. Research shows EFCs reduce social isolation and increase independence of older people, thereby reducing the risk of elder abuse (Bagshaw et al 2009). EFC projects have been implemented in urban and rural South Australia, based on the Calgary model. Extensive evaluations have shown positive outcomes for older people (Bagshaw et al 2009).

- **Tongan community campaign against domestic violence**, Sydney, provides an example of an ethnic-specific, community mobilisation approach involving a Pacific ethnic group. The campaign included social marketing and the use of Tongan community representatives to develop culturally and linguistically appropriate campaign materials. It also took a positive approach, emphasising "peaceful and harmonious" families and healthy, respectful relationships. Evaluation results included increases in Sydney Tongans' knowledge about domestic violence, and increased recognition of domestic violence as a crime (Percival et al 2010).

New Zealand examples of community development interventions

- The **Violence-Free Communities Project**, Te Aroha Noa Community Services in Highbury, Palmerston North used a community conversation process involving community consultants – local people with experiences and views on local violence – to develop strategies for reducing violence (both primary and secondary prevention). It focused on activity-based learning, network-oriented prevention efforts, and the use of action-reflection. The use of local people as consultants drew on Te Aroha Noa's approach, where all people are considered both teachers and learners (Sanders et al 2012).

Evaluation found the community conversation process was effective in both raising awareness and creating change, e.g. individuals reported increased confidence to challenge violence, and were better able to attempt to create change within their own families. It also found that understanding of violence increased. There was some evidence of organisational change. The project also succeeded in building momentum and future sustainability, as the evaluation research showed that after the formal funded initiative ended, work towards creating a violence-free community had intensified and become integral to the Te Aroha Noa organisation (Sanders et al 2012).

Success factors identified in the evaluation included being theory-driven, and the existing strong relationships, support and shared history of Te Aroha Noa (local people knew and trusted the organisation and its commitment to the local area). Five broad theories informed the project: structural community change theory, ecological perspectives, Frierian educational theories, strengths-based approaches, and complexity theory.

Bystander interventions

Engaging bystanders is seen as a promising strategy in preventing partner and sexual violence before it occurs. It is supported by early but growing evidence (VicHealth 2012a, Powell 2011, Casey and Lindhorst 2009). A bystander is defined as someone who observes an act of violence, intimidation or other unacceptable behaviour – distinct from the victim or perpetrator (VicHealth 2012a).

Originally, bystander models were focused on intervening at the time of a violent incident. In contrast, primary prevention is increasingly adopting bystander approaches to influence *upstream* actions before violence has occurred, e.g. sexual harassment, sexist behaviour, or discriminatory practices (VicHealth 2012a, Powell 2011, Casey and Lindhorst 2009). Broad bystander actions may include confronting peers who make sexist jokes or harass women, or talking to a manager about unfair treatment of women in the workplace (VicHealth 2012a).

Bystander interventions have typically been used either within broader interventions, such as social marketing or peer education/peer support, or as stand-alone programmes in workplaces or other organisations, e.g. sports clubs.

Bystander interventions at community or societal levels are also seen as potentially effective, requiring consideration of community readiness to change and the appropriate tailoring of strategies to culturally diverse groups. Cultural tailoring of approaches is vital because community attitudes toward violence and the acceptability of intervening as a bystander can vary greatly across cultures (Powell 2011).

Organisations can themselves become more proactive 'bystanders', e.g. through their own policies, practices and leadership models and by promoting a culture that supports bystander actions (Powell 2011).

Researchers recommend better articulation of theoretical rationales, and greater clarity about the specific mechanisms for translating bystander programme activities into behaviour or community-level change (Casey and Lindhorst 2009). They say that bystander strategies must be combined with strategies to change social norms, since social norms are a key influence on bystander behaviour (Powell 2011).

Overseas examples of bystander interventions:

- **Bringing in the Bystander, US**, is a primary and secondary prevention programme using active learning and practice to teach bystanders how to intervene in situations where there is a risk of sexual violence. It is university-based and uses multi-session group learning with both genders. Ongoing evaluations are showing positive results in increasing bystander actions (Powell 2011).

- **Sex and Ethics programme, Australia.** This community-based, comprehensive programme with young people aged 16-25 years was developed in New South Wales and is now also used in New Zealand, e.g. by the Wellington Sexual Abuse Network. It focuses on skill development and critical reflection on sexual decision-making, and emphasises negotiation and capability development rather than risk avoidance (Carmody et al 2009).

Other promising bystander examples, that have not yet been fully evaluated, include the **Step UP! programme**, a US university-based intervention, that promotes bystander behaviour across a wide range of social issues including violence (Powell 2011); the US **Green Dot programme** (DeGue et al 2012b), and the **Respect and Responsibility** intervention in Australia (Powell 2011). In this last example, the Australian Football League works with VicHealth on a range of strategies, e.g. model anti-harassment and discrimination policies for clubs, organisational policies and procedures, changes to AFL rules on sexual assault, and targeted education programmes (Powell 2011).

A recent telephone survey by VicHealth, to inform broad bystander action, found that almost half of respondents who had witnessed violence or discrimination reported taking action, but respondents were more hesitant to respond to more subtle forms of sexism like sexist comments or jokes (VicHealth 2012a). Young people (aged 18-34) in the survey were most likely to have witnessed sexism or violence, but least likely to have taken bystander action. Women were more likely to intervene as a bystander compared with men. These results suggest that men and youth are important target groups for bystander programmes.

Working with men and boys to change social and gender norms

Emerging evidence supports the use of primary prevention with men and boys, aiming to change social and gender norms (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Adolescent males or younger boys are increasingly targeted using either universal or selective programmes, delivered through school-based initiatives, community mobilisation, and/or public awareness campaigns (World Health Organization and London School of Hygiene and Tropical Medicine 2010, Robertson and Oulton 2008).

Men's groups are increasingly organising men to commit to anti-violence activism (Casey and Lindhorst 2009). Typical aims are challenging community and peer norms that support violence, redefining masculinity, confronting peers' violent behaviour, mentoring younger boys, and providing support to men for speaking out. Another approach is the 'pledge' concept, where – typically – young men are asked to commit publicly to be non-violent themselves, and to speak up about other men's violence, e.g. Men of Strength clubs and Mentors in Violence Prevention in the US (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

There are some tensions inherent in the organising of men, as a privileged social group, to address a community problem that is perpetrated mainly by men. Experts recommend that men's groups consult adequately with women and women's groups (Casey and Lindhorst 2009).

Overseas evaluated example of working with men and boys

- **The Men's Program** is a longstanding bystander approach which engages men as "potential helpers" (Foubert 2000, cited in Powell 2011). Multiple evaluations have demonstrated long-term changes in men's attitudes and behaviour, e.g. decreases in sexually-aggressive behaviour, rape myth acceptance and likelihood of raping, and increased willingness to curtail sexist comments (Casey and Lindhorst 2009).

Promising examples of working with men and boys

- **Men Can Stop Rape**, US, which includes workshops (e.g. Men of Strength clubs for adolescent and young adult men), train-the-trainer, and a social marketing campaign – all focused on pro-social bystander promotion to prevent violence against women. It is not yet systematically evaluated, but programmes are widespread in the US – over 100 examples exist across high schools and communities (Powell 2011). One pre/post evaluation of Men of Strength clubs found that high school boys reported a greater willingness to intervene in a scenario involving inappropriate touching of a young woman (Casey and Lindhorst 2009).

- **Men Against Sexual Assault,** Australia, is an organisation of men working to eliminate violence. It comprises men's groups and patriarchy awareness workshops in workplaces (Powell 2011).

- **White Ribbon Campaign,** Australia (and New Zealand) – encourages men to pledge not to commit or remain silent about violence against women. This well-known programme includes education and leadership programmes aimed at men and boys (Powell 2011). Internal evaluation suggests the campaign has helped to increase reporting rates and to decrease public tolerance to violence[6].

New Zealand examples of working with men and boys

- The **Mana Tane project** with Māori men in Northland (by Amokura) has highlighted the importance of males taking responsibility to change their behaviour (with the support of others). This project also found that transformative behaviour can only occur if prevention directed at Māori men is grounded within an ideology that challenges gender power inequalities (Ruwhiu et al 2009).

- **Tairawhiti Men Against Violence** is a group of about 50 men in the Gisborne region who are committed to challenging themselves and other men to be 'good people' in their families, workplaces, and wider community. Activities include promotion initiatives, White Ribbon events, family sports days, and wananga for men on the causes of violence, and establishing a Men's Resource Centre in Gisborne (Ministry of Social Development 2011).

An example which illustrates the challenge of shifting male attitudes and behaviours is the **Violence Against Women; It's Against All the Rules** campaign (New South Wales, Australia). It targeted 21–29 year-old men and aimed to influence their attitudes. Sports celebrities delivered the message that violence towards women is unacceptable and that non-violence is more masculine. It also sought to enhance the community's capacity to challenge and address violence against women. A post-campaign survey indicated some positive results: 83% of the respondents could recall the campaign message and

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[6] http://whiteribbon.org.nz/2012/03/09/white-ribbon-report-for-2011/

59% recalled the slogan. However, 91% of the target group also said they would not talk about the issue with their peers, irrespective of the campaign.

Community social norms programmes and social marketing

Cultural and social gender norms are the rules and expectations which regulate the roles and relationships of men and women within a specific cultural or social group (World Health Organization and London School of Hygiene and Tropical Medicine 2010). The "community social norms" approach aims to change wider community perceptions that violent behaviour is acceptable or 'normal'. The theory is that people tend to misjudge the behaviour of others, usually thinking that unhealthy or violent behaviour is more prevalent. Social norms programmes aim to rectify these misperceptions by increasing awareness of actual behavioural norms, hence affecting behaviour (Quadara and Wall 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010). Such approaches are important in preventing sexual violence, because strong predictors of perpetration include 'hyper-masculinity' (strong endorsement of traditional male gender roles), rape-supportive attitudes, and membership in social networks with rape-supportive norms (Casey and Lindhorst 2009).

Programmes to alter cultural and social norms are one of the least evaluated strategies for preventing partner and sexual violence (Bellis et al 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010). However, some evidence in this area is emerging (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Effectiveness of interventions on dating violence and sexual abuse among teenagers and young adults (through challenging social and cultural norms related to gender) is supported by some evidence (World Health Organization 2010). Other promising interventions include those targeting youth violence and education through entertainment – 'edutainment' (World Health Organization 2010).

Social marketing

Social marketing is not – or should not be – just a media campaign in isolation. Social marketing uses a range of multi-level strategies, associated activities and programmes (Powell 2011), and a range of marketing and social change techniques – not just advertising.

Social marketing campaigns are among the most common approaches to prevent violence, so practice knowledge and resources are well developed. Campaigns aim to address attitudes and social norms, which are critical determinants of violence (VicHealth 2007).

Evidence suggests that social marketing can be effective in increasing awareness of violence, facilitating behaviour and attitudinal change, changing social norms, and promoting a climate for violence prevention – especially as part of a wider comprehensive strategy for behavioural and environmental change (Powell 2011, VicHealth 2007). It can also drive other prevention work and help to build political will to prevent violence (Bellis et al 2012, National Council to Reduce Violence against Women and their Children 2009).

In contrast, the use of media messages alone, particularly in one-off or short-term campaigns, is not effective in changing behaviour (Braaf 2012, Bellis et al 2012).

Evaluated New Zealand approach

- New Zealand's **It's Not OK** campaign is a comprehensive social marketing campaign that intervenes at both community (e.g. community action, local partnerships, media advocacy) and

societal levels (e.g. mass media advertising, media advocacy guidance and training for reporters, national partnerships). Its Community Action Fund supports communities to take a community development approach and has funded 147 projects between 2007 and 2010 (Ministry of Social Development 2011). It is focused on primary, secondary, and tertiary prevention.

In a review of 16 campaigns from five countries, the It's Not OK campaign received top rankings as one of only two campaigns that sought to address most of the stages of change, and most of the main influences on behavioural intention and behavioural change (Cismaru and Lavack 2011). The campaign also won an international award for communication in 2009 (Point Research Ltd 2010).

New Zealand evaluation suggests the campaign is impacting on public awareness, attitudes and behavioural intentions (Ministry of Social Development 2011, Point Research Ltd 2010), although the impacts on actual violence have not been studied. Key findings related to behaviour include increases in men seeking help to change behaviour, increased motivation to act on issues of family violence (e.g. 1 in 3 respondents said they had discussed or spoken up about family violence, or became involved in helping in 2010), and a large increase in the number of people who felt they could influence someone to change their behaviour. Positive changes in media portrayal of violence have been reported, as well as greater collaboration and partnerships (Point Research 2010).

The campaign appears to have reached Māori, who had the highest recall of the campaign advertising (Point Research 2010). As noted, E Tu Whānau! and Pasefika Proud campaigns are newly developed ethnic-specific campaigns, emerging from the It's Not OK campaign.

Promising approaches (E Tu Whānau! is discussed in the next section, Section 5.3)

- The **Pasefika Proud** campaign is underway in New Zealand, but is not yet evaluated. The Pacific Advisory Group to the Taskforce for Action on Violence within Families developed the Pasefika Proud brand to unite and publicise all violence prevention work in Pacific communities. Recent concept testing of the brand at a large festival (Polyfest 2012) showed almost universal support from Pacific young people for the brand and logo (Ministry of Social Development 2012). Suggested improvements included making the anti-violence message more explicit in the campaign's resources. An early evaluation of another social marketing campaign, Breaking the Cycle, found that Pacific peoples reported the highest incidence of actual behaviour change (Percival et al 2010).

- The **Dignity in Care campaign**, UK, aims to change attitudes towards older people in care by raising awareness of the need for dignity and respect, and motivating health and social care workers and the public to take action. It provides recommendations for hospitals and care homes to help them identify the causes of failures in the care system and to deliver dignity in care (VicHealth 2007).

Social norms marketing campaigns

Social norms marketing campaigns, in particular, have been most commonly applied on university campuses in the US (Casey and Lindhorst 2009). They aim to 're-educate' students on the reality of low levels of support for unhealthy or unacceptable behaviour.

Findings on social norms campaigns are mixed. Randomised controlled trials have shown some success from alcohol-related social norms marketing campaigns in colleges. One US university project used a social norms marketing campaign to target men, alongside a theatre presentation and male peer-to-peer education. A post-campaign evaluation found that after 2 years men had more accurate perceptions of other men's behaviour, and improved attitudes and beliefs about sexual violence (Bellis et al 2012). However, other research has not demonstrated any impact (Casey and Lindhorst 2009).

Despite a lack of rigorous evaluation, college campuses and other settings in the US are increasingly implementing social norms marketing campaigns on the importance of respectful and non-violent relationships, or of intervening as a bystander. Though acknowledging the need for rigorous evaluation, researchers conclude that social norms campaigns are useful as part of a multi-level, comprehensive approach (Casey and Lindhorst 2009).

Settings approaches to change social and gender norms

Recent literature, e.g. from Australia, suggests the potential of settings-based approaches. Schools are an important area, because of the pivotal stage of adolescents and evidence of effectiveness. A range of other key settings are also used for prevention (Quadara and Wall 2012), e.g. workplaces, churches and other faith organisations, health centres, and local government.

Pacific churches

Churches are a key setting for prevention with Pacific communities (Percival et al 2010, Robertson and Oulton 2008). A 2009 review recommended that prevention should align with existing community health promotion systems such as fono or church meetings – and emphasise oral and visual, over written, material (Percival et al 2010).

Public attitudes of denial or misapprehension of effective child discipline are thought to underlie much of Pacific girls' vulnerability to violence. UNICEF has recommended that public campaigns in the Pacific region target the clergy and church organisations, teachers and law-makers, as well as community based prevention and the promotion of non-violence as a cultural value (Percival et al 2010).

Example of settings-based intervention to promote gender equality

- **Respect, Responsibility and Equality (RRE) program,** Australia, uses settings-based approaches to promote gender equity in five recent projects (VicHealth 2012b). The projects are based in diverse settings (e.g. corporate workplace, local government, youth-focused practitioners). A recent evaluation reports that RRE has achieved changes on both the *individual* level (e.g. improved understandings of the underlying causes of violence against women) as well as "significant impacts" at the *organisational/community level.* These included: organisational promotion of gender equity and normalising discussions about gender equity, and organisational policies that support primary prevention to occur.

  The report says that prevention must work on multiple levels (individual, community and societal). Community readiness, as well as intensive resourcing, is needed to show results. The report concludes that the programme shows that achievable steps can be taken towards *societal*-level change. However, it also stresses the need for long-term and sustained strategies, with an explicit focus on sustainability. Though the positive changes were impressive, it was harder to get sustained impacts at the organisational/community level (VicHealth 2012b).

Partnerships/coordinated community interventions

Partnerships between schools, families, communities, and public services can play a key part in violence prevention generally (Bellis et al 2012, World Health Organization 2002). Various coordinated enforcement and prevention approaches often take place, typically focusing on youth or alcohol-related violence (Bellis et al 2012). In New Zealand, Māori and Pacific literatures stress the importance of cross-sectoral partnerships to address the multiple factors associated with violence (e.g. Cooper 2012, Siataga 2011, Percival et al 2010).

Evaluated examples

- **Communities That Care** programme (US) uses community engagement to collectively identify local risk and protective factors for youth problems, and to select appropriate interventions, e.g. community-based support for youth combined with school-based life skills and parenting programmes. Research has found that children from CTC communities were less likely to become involved in violence and other problems (Bellis et al 2012).

- **Dating Matters** is a US prevention programme aiming to prevent teen dating violence in high-risk urban communities. This evidence-based programme includes preventive strategies for individuals, peers, families, schools, and neighbourhoods (DeGue et al 2012b).

A promising example in Australia is the **Alliance for the Prevention of Abuse**, South Australia, which is a collaboration to challenge the way elder abuse is understood and addressed. The collaboration involves legal, advocacy, medical, and mental health services, to recognise that elder abuse is broad and multi-faceted. Researchers also note that domestic violence professionals should be included in such alliances to encourage collaboration between the fields of elder abuse and domestic violence (Bagshaw et al 2009).

SUMMARY OF COMMUNITY-LEVEL APPROACHES:

International researchers consider that community-based approaches have much potential, and evidence of effectiveness is emerging. Community development and mobilisation strategies are increasingly used and have promise, e.g. Elder-Friendly Communities in Canada and Australia, and the Violence-Free Communities project in New Zealand. Growing evidence supports bystander approaches. Examples identified for this review are located in the US and Australia.

Men and boys are increasingly targeted in primary prevention and evidence of effectiveness is mounting, e.g. the US-based Men's Program. Community social norms and social marketing approaches are commonly used and considered effective if multi-level and part of a wider prevention strategy, e.g. the "It's Not OK" campaign in New Zealand.

5.3   Indigenous-led approaches

International indigenous literature

At present, the evaluation literature on indigenous family violence prevention is more limited than generic literature (Cooper 2012, Carmody et al 2009, Whitaker and Reese 2007, Memmott et al 2006). Most available research is on tertiary rather than primary prevention. Because of the overwhelming needs in indigenous communities, violence prevention practitioners and researchers often have lower

capacity, training opportunities and resources to formally document and evaluate projects (Memmott et al 2006). Much of the current indigenous literature is qualitative research, exploring cultural dynamics and participant perspectives. This is still useful for informing what might work and why (Shea et al 2010) but does not demonstrate effectiveness.

The generic literature on good practice in prevention of partner and sexual violence does not usually consider indigenous peoples specifically (Whitaker and Reese 2007). There are also potential tensions between Western and indigenous models of research and knowledge.

Nonetheless, a large amount of indigenous-led prevention work is underway, especially at grass-roots levels. Australian researchers, for example, report that good practices are widespread in Australia, however formal documentation and rigorous evaluation of this preventive work is lacking (Victoria Department of Human Services 2012, Memmott et al 2006). In Australia, consultations to inform the Victorian *Indigenous Family Violence Primary Prevention Framework* revealed high levels of concern about family violence, and that the most supported prevention initiatives were those endorsed by indigenous elders or leaders, and run by communities (VicHealth 2010, cited in Success Works 2011). This indicates that buy-in is important.

Māori literature

New Zealand had very little literature on whānau violence until the Te Rito strategy in 2002, when government priorities shifted toward greater funding for research, strategy and taskforces on family violence including Māori-specific approaches (Cooper 2012). Still, the local Māori-specific research base remains relatively small.

In 2004 the Mauri Ora framework for transforming whānau violence was released (Kruger et al 2004), which identified three central tasks:

1. Dispelling the illusion (at collective and individual levels) that whānau violence is normal and acceptable
2. Removing opportunities for whānau violence to be perpetrated through education for empowerment and liberation of whānau, hapū and iwi, and:
3. Teaching transformative practices based on Māori cultural imperatives that provide alternatives to violence (Kruger et al 2004).

The Maura Ora framework has been widely endorsed in later literature and commentary (Cooper 2012). The Government also funded Project Mauri Ora, a national training pilot programme for Māori practitioners, based on the framework. This training was then expanded and continues to be funded and delivered nationwide through an indigenous education and training provider, Te Korowai Aroha o Aotearoa (Cooper 2012). A Māori-specific action plan, *E Tu Whānau-ora: Programme of Action for Addressing Family Violence 2008-2013*, is closely aligned with existing and proposed Māori models of prevention (Cooper 2012).

Example of a Treaty-based partnership

Providers of specialist services for sexual violence prevention and intervention in New Zealand have a national network, Te Ohaakii a Hine – National Network Ending Sexual Violence Together. The structure is a bicultural partnership based on Te Tiriti o Waitangi (the Treaty of Waitangi), with a Māori caucus of those providing kaupapa and tikanga Māori services, and a Tauiwi caucus for all other services. The two work autonomously and together on common concerns in line with their own perspectives and priorities

(Dickson 2013). This partnership structure may provide opportunities and support for the development of Māori-specific, Māori-led approaches to the primary prevention of sexual violence. The National Collective of Women's Refuges Inc. (NCIWR) has a similar structure.

Approaches considered likely to be effective for indigenous populations

Māori literature highlights the value of designing and delivering holistic whānau violence prevention using Māori concepts, values, and approaches. It also recommends incorporating analysis of the historical and contemporary impacts of colonisation for Māori, e.g. using decolonisation and re-enculturalisation strategies (Cooper 2012, Te Puni Kōkiri 2010 and 2009, Pihama et al 2003).

Integrated approaches – as opposed to separating out various types of violence – are recommended. This better suits indigenous approaches to relationships and interconnections (Cooper 2012, Carmody et al 2009). Researchers recommend that sexual violence prevention programmes for indigenous people should be included in the broader context of family violence or community violence.

In general, advice from the indigenous literature highlights the potential effectiveness of: holistic community development and strengths-based approaches; supporting existing indigenous work and networks; developing and enhancing relationships between community and government agencies; and cultural strengthening (Success Works 2011). It stresses the need to increase indigenous populations' access to resources, such as education, employment, housing, parenting support, and support for dealing with alcohol and other substance misuse.

Positive relationship training, e.g. through healthy and respectful relationships education in schools or family support programmes, are also promoted in some indigenous literature (Victoria Department of Human Services 2012). Indigenous researchers generally agree that addressing the impact of alcohol-related violence is necessary to prevent indigenous family violence (Cooper 2012, Success Works 2011).

Prevention with indigenous young people

Some indigenous young people at risk of violence either attend school intermittently or have left altogether. According to New Zealand's Youth 2007 survey, 15% of all secondary school students reported truanting. Māori and Pacific students were more likely to truant than NZ European and Asian students (e.g. 28% of Māori students reported truanting compared with 12% of NZ European students)[7]. The literature highlights a need for interventions to target youth at risk in various settings, e.g. tertiary education and trades training, sports contexts, and youth centres (Success Works 2011).

Next, we briefly summarise various examples of indigenous prevention programmes, first from overseas and then from New Zealand. These programmes give valuable insight into processes used, and likely success factors.

Overseas examples of indigenous approaches to prevention

Evaluated examples

- The **National Walking into Doors campaign**, Australia, is a social marketing campaign evaluated as successful (Memmott et al 2006). A critical success factor for indigenous communities was

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[7] Youth 2007 survey report on truanting, http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-truancy-report.pdf

the use of community forums, along with involvement of highly regarded musician mentors. The evaluation also noted that most service providers felt the community forum was effective only in raising awareness rather than necessarily changing behaviours – but was still seen as a key element in a wider strategy for prevention (Memmott et al 2006).

- The **Family Wellbeing and Empowerment Program** is a group learning programme developed by 'Stolen Generation' Aboriginal people. It teaches ways to overcome life challenges, aiming to help people become empowered to gain control over their lives and to increase community connectedness. A participatory action research project over a 10-year period reported positive impacts in helping Aboriginal individuals, families and communities to address grief and loss, and to take greater control and responsibility for issues affecting them. Participants become involved in addressing issues such as family violence, alcohol and drug misuse, and over-representation of Aboriginal men in the criminal justice system. The researchers note that the work of shifting social norms is slow, though, and that a high level of involvement is needed for community-level change (cited in Success Works 2011).

- **University of Arizona's Promoting Healthy Relationships project**, US. This dating violence prevention curriculum in schools[8] targeted American Indian and Hispanic youth in the context of a comprehensive, positive youth development programme. Four cultural communities were engaged. Survey, focus group, and interview evaluation data indicate that the project is being received favourably by participants and helping to improve their awareness of, and attitudes toward, dating violence (Whitaker and Reese 2007). An experimental evaluation for this project was not identified for this review. Key lessons learned included the importance of taking time to build relationships with stakeholders e.g. tribal councils, using local staff from within the cultural communities, and incorporating cultural beliefs into programmes (Whitaker and Reese 2007).

Promising initiatives reported in indigenous literature

- **Incite: Women of Color Against Violence, US,** is an activist movement which seeks to address violence against women in the context of constraints like racism and poverty. It uses community development techniques for prevention and awareness-raising. Its work is based on analysis of the "intersectionality" of violence, sexism, racism and other forms of oppression (Casey and Lindhorst 2009).

- **Use of indigenous camps (Australia)** as a prevention setting, e.g. camps for men on cultural strengthening and addressing violent behaviour, family camps, and youth camps. Community consultations suggest it is important to include both youth with challenging behaviour, and camps with a positive focus such as developing leadership skills of youth showing potential (Victoria Department of Human Services 2012).

- **Yirra Yaakin Noongar Theatre,** Western Australia, has operated since 1993, offering theatre performance and follow-up workshops on theme of 'family violence – no excuse'. It aimed to provide positive models of family relationships. The initiative has grown significantly as a community development approach and won awards, but we did not locate any evaluations. A

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[8] This programme is school-based so out of scope, but it is included here as this review found few examples of evaluated indigenous interventions.

reported success factor is the secondment of experienced indigenous family violence workers who contributed significantly to the project's development (Memmott et al 2006).

Examples of Māori approaches to prevention

Evaluated examples

- **Ngāti Porou community injury prevention project**. This iwi-based project aimed to prevent family violence as part of a collaborative, holistic community health project targeting various safety issues including family violence). Evaluation, based on pre/post community surveys, found a small increase in those who 'always or mostly' walk away from a threatening situation in the home, and a significant increase in awareness (Cooper 2012, Shea et al 2010). Actual rates of family violence within the community were not assessed as part of the work.

  Still, process evaluation suggested the project was successful in applying a Māori cultural framework to prevention and in meeting Māori aspirations. Participant observation identified a high level of participation and whole-of-community support for the work. The project highlighted good use of partnerships with community organisations and stakeholders, e.g. various marae, Māori organisations and sporting groups (Memmott et al 2006).

- The **Amokura Family Violence Prevention Strategy** (Te Tai Tokerau iwi consortium of seven iwi authorities in Northland) was a comprehensive community initiative comprising research, education and promotion (with a social marketing focus based on evidence, the *Step Back* campaign), professional development and training, and advocacy work at a policy level (Grennell and Cram 2008). Using Māori frameworks and collective responses, it aimed to prevent a range of health, social, and other societal issues including violence, by coordinating community processes to engage individuals, families, organisations, and institutions.

  The evaluation was a process, rather than impact, evaluation. It found the project had met its objectives, and that participants reported positive outcomes and feedback in post-workshop evaluations. The evaluators noted that Amokura won an international human rights award, and that a related initiative's evaluation (Everyday Communities) reported positive outcomes from Amokura's work. They noted the high regard with which Amokura is held, and some positive 'ripple-out' effects to the whole Northland community (Grennell and Cram 2008). For example, word has spread about Amokura, the Consortium, 'Step Back' and the accompanying promotion of non-violence. Amokura is thought to have successfully linked its brand to other brands (e.g., Everyday Communities) which has reinforced its message to the wider community.

Other promising examples in New Zealand

- **E Tu Whānau! and It's All about Whānau campaigns** are Māori-specific social marketing/social change campaigns, which emerged from the generic It's Not OK social marketing campaign in New Zealand and is part of the broader E Tu Whānau Ora programme of action. Informed by research, these are strengths-based community campaigns directly involving Māori communities in preventing and addressing violence in families.

  E Tu Whānau builds on activities to strengthen whānau and to tackle issues in order to improve whānau wellbeing. It recognises and uses the power and effectiveness of Māori oral traditions, and delivers anti-violence messages that are designed, delivered and led by Māori. Messages

and stories that people share are being translated into booklets, DVDs, posters, cards, and in magazines and on radio. These resources are popular, and more than 700,000 have been distributed to family violence providers and agencies.

An unpublished 'exploratory assessment' on how service providers use E Tu Whānau resources suggests that practitioners are supportive of the resources and make use of them with clients (Ministry of Social Development, unpublished internal memo, 27 June 2012). Interestingly, the participating practitioners found that both Māori and non-Māori clients were engaged by the resources. This suggests that some Māori-led approaches may appeal to, and potentially be effective for, other ethnic groups.

- **Tiaki Tinana** is delivered within a kaupapa Māori framework by Rape Prevention Education, Auckland. It is a Māori response to sexual offending against children and young people (not specifically on intimate partner violence), and seeks to inform health promotion to prevent sexual violence in Māori communities. Pilot Tiaki Tinana workshops have been delivered throughout the Waikato, wider Auckland and Northland regions[9]. The aim is to raise awareness of sexual violence within Māori communities, and to create a dialogue among community leaders and within whānau, hapū and iwi about practical, everyday ways of incorporating sexual violence prevention strategies. Māori educators with extensive clinical experience provide a "uniquely Māori clinical lens".

  Tiaki Tinana's work to date has reportedly been of value to participating Māori communities, and strengths include the kaupapa Māori approach and the translation of clinical information into everyday language. The programme effectively integrates cultural and clinical expertise. It has had close community involvement at all stages of development, which is crucial in dealing with such a sensitive topic.

- **Ngāti Kahungunu Violence Free** project is an example of iwi-based prevention, which engaged rangatahi (youth) in a violence prevention education programme, resulting in a drama production delivered to several communities within the region (Cooper 2012).

- **Waananga Whakamana** programme for high-risk offenders and their whānau is an intensive, marae-based, semi-residential programme (Cooper 2012). Workshops as part of the programme include: anger and violence prevention; drug, alcohol and substance use; parenting and relationship skills and whānau dynamics; cultural identity; whānaungatanga; colonisation; and the Treaty of Waitangi (Atkinson 2003). A key reported success factor is strengthening or restoring Māori cultural identity (Cooper 2012). Our review did not identify an outcome evaluation of this programme.

Learning from New Zealand qualitative research

Erana Cooper (2012) recently completed PhD research with Northland iwi (Ngāti Hine), whānau, and practitioners working with whānau violence. She examined the views of whānau and practitioners on what works to prevent or stop whānau violence. Though the research was not an evaluation of effectiveness, it provides useful insights from Māori practitioners and whānau.

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[9] Te Puni Kōkiri case study, http://rpe.co.nz/wp-content/uploads/2011/12/Tiaki-summary-2.pdf

Positive approaches

Consistent with the broader literature's emphasis on positive, strengths-based approaches to prevention, the iwi representatives who took part stressed the importance of having an aspirational vision for healthy whānau in the future, along with promoting collective strategies toward whānau ora currently. Interestingly, research participants highlighted the presence of hope as essential in preventing or stopping violence, e.g. holding strong hope for a better future for themselves and their whānau – particularly their children (Cooper 2012).

The participants in Cooper's research raised specific strategies for effective prevention, which also align with international literature, e.g. the early identification and treatment of alcohol and drug use, reducing financial stress, and the value of learning and practising skills like parenting, communication, and accepting responsibility for behaviour. The centrality of whakawhānaungatanga – connections and relationships – was identified by all three participant groups (Cooper 2012).

Kaupapa Māori approaches

Cooper's research confirmed the need for a Kaupapa Māori, whānau-centred, transformative model of practice. In discussing implications of the research, Cooper underlines the need to see individuals as integral to whānau, and in turn, that whānau is inseparable from the wider hapū. This suggests that some violence prevention programmes may need to adjust to reflect this integration.

Other findings included the use of skill development and behaviour change strategies in prevention work, and the teaching and modelling of Māori values, beliefs, and attitudes. A "fusion" of cultural and clinical competence was seen as important (as in Tiaki Tinana, listed above), along with strong Māori organisational structures and teamwork (Cooper 2012).

Generic approaches that may suit indigenous populations

Generic reviews did not tend to report on the effects of primary prevention interventions on indigenous populations. Some researchers have noted the potential of bystander and male-focused approaches for preventing indigenous violence, e.g. men's anti-violence groups. In the US some male anti-violence groups include speaking out against multiple forms of violence, including sexism and racism (Casey and Lindhorst 2009).

The 'community readiness' model has been used with Native American populations in the US and is thought to have promise (Carmody et al 2009, Robertson and Oulton 2008). It charts nine levels of readiness for change within a community. As noted already, an essential part of community readiness in indigenous communities lies in addressing the intergenerational trauma of violence, colonisation, and marginalisation.

SUMMARY OF INDIGENOUS APPROACHES:

Indigenous-led approaches are currently under-researched in New Zealand and overseas, but promising practices are increasingly emerging. Indigenous researchers say the approaches most likely to have success include: strengths-based and community development approaches, cultural and family strengthening, integrating cultural and clinical competence, partnerships between indigenous communities and various agencies, and focusing on alcohol and drug use, along with children and youth at risk.

Addressing collective grief and trauma from the intergenerational and continuing impacts of structural factors like colonisation and racism is important to incorporate within indigenous primary prevention efforts. Evaluated New Zealand primary prevention programmes include the Ngāti Porou Community Injury Prevention project, and the Amokura Family Violence Prevention Strategy.

5.4   Approaches to reduce alcohol-related harm

Alcohol is closely associated with intimate partner violence and elder abuse (Bellis et al 2012, Braaf 2012, World Health Organization undated). Although not always a factor – not all drunk people are violent and not all violence involves alcohol – it is generally accepted that alcohol is "deeply implicated" in partner and sexual violence (Memmott et al 2006). More than a third of offenders and a quarter of victims of serious sexual assault have reportedly consumed alcohol before the incident, for example (Bellis et al 2012). Victims of partner violence and elder abuse may develop drinking problems as a way to cope with violence (Braaf 2012).

Alcohol and intimate partner violence co-occur

Family violence practitioners seek to avoid misrepresenting alcohol as a *direct* cause of partner abuse, as this may reduce perpetrator responsibility and fail to target the root causes (Braaf 2012). Alcohol and intimate partner violence are thought to 'co-occur'. This is endorsed by evidence showing alcohol to be strongly associated with intimate partner violence when a partner already holds violence-supporting and controlling attitudes. This approach suggests that where alcohol misuse co-occurs with attitudes and behaviours supportive of violence against women, abuse is more likely to happen – to escalate (Braaf 2012).

There is a risk that some interventions to reduce alcohol misuse may be unsafe and expose victims to further abuse if they fail to address co-occurring intimate partner violence (Braaf 2012). To address this risk appropriately, staff in alcohol and drug treatment services need to have a thorough understanding of the dynamics of intimate partner violence. Nonetheless, New Zealand family violence practitioners and researchers call for reducing the impact of alcohol and drugs as part of violence prevention (Ruwhiu et al 2009).

Ageing may reduce older people's tolerance to alcohol, causing alcohol-related problems at lower levels of drinking (World Health Organization undated). Health practitioners may mistake signs of elder abuse for the effects of alcohol use – and vice versa. As noted earlier, health practitioners need to be trained to recognise and respond to the signs of abuse in later life. Misconceptions and ageism must also be addressed, e.g. the perception held by some health professionals that social withdrawal and memory problems are 'normal' signs of ageing (World Health Organization undated).

State of evidence

Alcohol's close links with intimate partner and sexual violence suggest that primary prevention efforts to reduce the harm caused by alcohol have potential to contribute to violence reductions (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Interventions to reduce problem drinking, in particular, are judged as "well supported by evidence" for preventing intimate partner violence (World Health Organization 2010).

Also, the World Health Organization (2010) states that "emerging" evidence supports other alcohol-focused strategies (e.g. making alcohol less available by raising the price of alcohol, reducing density of

outlets, and controlling alcohol sales) in preventing intimate partner violence, sexual violence, youth violence, and elder abuse. Research strongly indicates that as the availability of alcohol increases, alcohol consumption and related harms also increase – and vice versa (Braaf 2012). These strategies are designed to reduce general social harms from alcohol misuse, rather than partner and sexual violence specifically, but may affect the likelihood of violence occurring.

Potential effectiveness of alcohol-related interventions in preventing partner and sexual violence can be maximised through the use of concurrent strategies to challenge attitudes and behaviours that support violence towards women (Braaf 2012). Researchers call for more collaboration between alcohol and family violence sectors to enhance prevention, e.g. integrated social marketing campaigns can combine messages on the unacceptability of *both* family violence and excessive drinking (Braaf 2012).

Examples of overseas interventions to reduce alcohol harm

- **Intensive programmes with partners of problem drinkers**, aimed at reducing problem drinking, have shown reductions in intimate partner violence (Bellis et al 2012). In the US, treatment for alcohol dependence among males was found to significantly decrease intimate partner violence at both 6 and 12 months after the treatment intervention (Stuart et al. 2003, cited in World Health Organization and London School of Hygiene and Tropical Medicine 2010).

- **Screening and brief interventions to reduce problem drinking** – Several trials have shown that brief interventions and longer term treatment for problem drinkers, e.g. using cognitive behavioural therapy, have achieved reductions in both intimate partner violence and child maltreatment (Bellis et al 2012, World Health Organization 2010).

- **Reducing the density of alcohol outlets** – Emerging evidence suggests that reducing density is likely to reduce violence, and a greater density of outlets is associated with higher levels of both violence and alcohol consumption (Bellis et al 2012, Braaf 2012). Several US and Australian studies have pinpointed associations between alcohol outlet density and intimate partner violence in particular (Braaf 2012). One US study found an increase of 10 alcohol outlets per 10,000 people was associated with a 34% increase in male-to-female intimate partner violence, with adjustment for socioeconomic factors (Braaf 2012).

- **Controlling alcohol sales** – Studies show mixed results, but reduced sales hours are generally associated with reduced violence (Braaf 2012, World Health Organization 2010). A 2009 review of 15 studies found extended sales hours were associated with higher drinking levels and drink-related harm (Braaf 2012). An Australian community intervention, which included restricting the hours of sale of alcohol, reduced the number of intimate partner violence victims presenting to hospital (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Another study in Australia found that restriction of pub closing times in central Newcastle was associated with a relative reduction of 37% in night-time assaults (Bellis et al 2012).

- **Increasing the price of alcohol** is an effective means of reducing alcohol-related harm in general, which may help to reduce partner and sexual violence (Braaf 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010). Research suggests that increasing the price of alcohol can reduce both alcohol consumption and violence, including rape (Braaf 2012). Currently these effects have only been studied with youth or adult

populations, so there is a need to measure the specific effects of increasing price on elder abuse (World Health Organization undated).

A Canadian study in British Colombia estimated that a 10% increase in the minimum price of alcohol reduced consumption by 3.4% (Bellis et al 2012). A US national study examined the relationship between alcohol prices across states and the rates of intimate partner violence. It found that increases in price per ounce of pure alcohol reduced the likelihood of partner violence toward female partners (Braaf 2012). Also, economic modelling strongly suggests that raising alcohol prices (e.g. increased taxes, minimum price policies) can lower consumption, and hence, reduce violence (World Health Organization 2010).

SUMMARY OF ALCOHOL-RELATED APPROACHES:

The strong co-occurrence of alcohol with intimate partner violence and elder abuse suggests that reducing the harmful impact of alcohol is a key way to prevent violence before it occurs. Interventions to reduce problem drinking are well-supported by evidence, e.g. intensive treatment for alcohol dependence and brief interventions. Emerging evidence supports general alcohol harm reduction, e.g. reducing the availability of alcohol, raising the price, and improving the safety of drinking venues. Researchers advocate greater collaboration between alcohol and family violence sectors, and combining alcohol prevention with strategies to change violence-supporting attitudes and behaviours.

5.5   Approaches targeting children and youth, especially those at risk

A compelling case exists for focusing primary prevention on younger age-groups (in the context of families and whānau), and for supporting families more generally so they can better support children and young people. Solid evidence endorses the success of early intervention in preventing later multiple problems (VicHealth 2007).

Risk and protective factors for partner and sexual violence are well-known and include child and youth factors (Bellis et al 2012, World Health Organization and London School of Hygiene and Tropical Medicine 2010, National Council to Reduce Violence against Women and their Children 2009, VicHealth 2007). New Zealand evidence, from the Dunedin longitudinal study, found the strongest risk factor for intimate partner violence perpetration and victimisation, for both genders, was a background of physically aggressive offending, as a perpetrator, before the age of 15 (Hassall and Hanna 2007).

Experiencing or being exposed to family violence in childhood is strongly associated with later involvement in family violence (VicHealth 2007). Also, violence perpetration is more common in adolescence, and young men are more likely than older males to have attitudes that endorse violence. Reflecting this in part, the prevalence of violence against women is highest among young women compared with other age-groups (VicHealth 2007).

In the New Zealand context, a focus on children and youth is appropriate as both Māori and Pacific populations are relatively young populations. For instance, 38% of the Pacific population are aged under 15 years (Siataga 2011).

Strength of evidence

Primary preventive interventions with children and youth are endorsed by some of the strongest evidence in the field of violence against women (World Health Organization 2010, VicHealth 2007). These are often, but not always, in school or early childhood education settings. Some evidence on cost-

effectiveness is also emerging (Bellis et al 2012). Still, there remains a lack of robust research with Māori and Pacific population groups (Cooper 2012, Siataga 2011).

Intervening in school settings is by far the most common strategy for violence prevention with young people (VicHealth 2007), and as noted, a variety of programmes report success in changing both attitudes and behaviour (World Health Organization 2010). But as noted, some youth 'at risk' of violence do not attend school regularly or at all (e.g. 15% of secondary school students in New Zealand report truanting from school[10]). Prevention efforts need to reach children and youth living in justice or care and protection contexts, homeless young people, gang members, and young parents (Carmody et al 2009). Other settings, such as sports clubs, music or arts initiatives, are key sites for prevention.

Dating violence prevention

Dating violence is understood as an early form of intimate partner violence. Successful prevention of dating violence is likely to also prevent intimate partner violence and sexual violence later in life, because dating violence can be a major risk factor for these forms of violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Dating violence programmes have been relatively well-evaluated, compared with other efforts to prevent intimate partner violence (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Most programmes are school-based so are not detailed here. A focus on healthy, respectful relationships is considered important.

US and Canadian evaluations dominate the dating violence literature (Leen et al 2013). As noted, these "culture-bound" programmes may not transfer well to other countries or cultural contexts (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Adapting existing programmes requires the identification of content components of the programme that are critical to success. Delivery in culturally appropriate ways is also vital.

- Some comprehensive and rigorous evaluations of US and Canadian dating violence prevention programmes show longer-term effectiveness in changing violent behaviour (e.g. *Safe Dates* which is largely a school-based programme). However, some programmes have only achieved short-term effects (Leen et al 2013). A recent review of literature concluded tentatively that longer-term success may be linked with a focus on behaviour rather than attitudes or intentions (Leen et al 2013). Yet these reviewers note the difficulty of divorcing behaviour from attitudinal change, stressing the need to aim for changes in both.

Social development programmes

Many dating violence programmes take a major focus on social development and life skills, such as problem-solving, empathy, conflict resolution, and anger management. As well, some broad programmes offer generic social skills development without any focus on violence prevention. These may help to prevent violence without explicitly aiming to do so.

Good evidence supports social development programmes – especially in preventing youth violence – although again this literature is dominated by North American studies (Bellis et al 2012, World Health

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[10] Youth 2007 survey report on truanting, http://www.fmhs.auckland.ac.nz/faculty/ahrg/_docs/2007-truancy-report.pdf

Organization and London School of Hygiene and Tropical Medicine 2010). Such programmes are usually – but not always – based in schools, and comprise a mix of universal programmes and those targeted to high-risk groups.

Working with high-risk children and youth

Dating violence prevention and healthy relationships education with high-risk youth, outside of school settings, has had some success.

- In Canada, the community-based *Youth Relationships* programme targeted 14–16 year-olds who had been maltreated as children (Leen et al 2013, World Health Organization and London School of Hygiene and Tropical Medicine 2010). It aimed to develop healthy, non-abusive dating relationships, while challenging stereotypes and cultural norms of male power and control (World Health Organization 2010). A randomised-controlled trial showed the programme significantly reduced actual incidence of adolescent dating violence over the long term – 16 months after the intervention (Leen et al 2013, World Health Organization and London School of Hygiene and Tropical Medicine 2010).

- An out-of-school brief intervention on healthy relationships (*Love U2*), targeted to high-risk, low-income young people, achieved positive results in changing knowledge, attitudes, and skills development, however no longer term effects or behavioural impacts were reported (Leen et al 2013).

Promising examples of work with high-risk children and youth, which may help to prevent future intimate partner violence or elder abuse:

- **Mentoring programmes** for high-risk youth have not yet been studied much, but some positive findings exist, e.g. a US school-based mentoring programme on self-esteem, relationship building, goal setting and academic enrichment reported positive effects on bullying, physical fighting and depression (Bellis et al 2012).

- **Community-based interventions with youth at risk**, e.g. the *Integrate* **model** in the UK which, in collaboration with youth gang members, aims to address mental health problems and associated social inequalities. A multi-disciplinary team, including psychologists and youth workers, engages with young people (e.g. one-on-one 'street therapy' in the community) to help them lead activities and to access education, training, and employment. An early ethnographic evaluation has suggested the Integrate scheme successfully engages hard-to-reach, vulnerable young people and promotes positive psychological changes (Bellis et al 2012).

Current evidence on **academic enrichment programmes** is inconclusive. These include study support and recreational activities for high-risk children and youth, held outside of school hours. Some US research has found mixed or even negative effects, but later evaluations of broader interventions in the UK suggest such programmes can help to reduce risk factors for violence, especially when delivered in disadvantaged communities (Bellis et al 2012).

Interventions with infants and children with experience of, or exposure to, family violence

The World Health Organisation notes there is emerging, not established, evidence of effectiveness in this area. However, these interventions are seen as vital because experiencing or witnessing family

violence is a proven major risk factor for experiencing or perpetrating violence (World Health Organization/London School of Hygiene and Tropical Medicine 2010).

Researchers in New Zealand say that greater priority should be given to exposure to intimate partner violence and the impact of violence on the parenting children receive in responding to 'vulnerable children' (Murphy et al 2013b). Evidence-based principles for protecting children and adults exposed to both child maltreatment and intimate partner violence include: holistic support for children, supporting the non-abusing parent, supporting the mother-child relationship, holding the perpetrator accountable, and being culturally responsive (Murphy et al 2013b).

Example: A meta-analysis examined 21 psychological interventions targeted at children and adolescents who had experienced child maltreatment. Results were positive, e.g. 71% of children who had psychological intervention appeared to be functioning better than their non-treated counterparts (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Early identification and treatment of conduct and emotional disorders in childhood

The early treatment of conduct problems has been shown to reduce violence (or other violence-related outcomes) in childhood. In Canada for instance, cognitive behavioural therapy delivered to 6-11 year olds with conduct problems has been linked with reductions in aggression and problem behaviour, particularly in girls and older children (Bellis et al 2012).

This area is assessed as 'potentially' effective by the World Health Organization in terms of intimate partner violence. Evidence suggests that childhood conduct disorders and other emotional or behavioural problems increase the risk of experiencing or perpetrating intimate partner violence in adulthood and the effectiveness of interventions to reduce conduct disorders is well-established (World Health Organization and London School of Hygiene and Tropical Medicine 2010).

Pre-school enrichment programmes

These programmes aim to develop young children's cognitive, emotional, and social skills before they start school. Most are targeted to children from disadvantaged communities, but some are universally provided (Bellis et al 2012). The World Health Organisation (2010) has assessed early childhood enrichment programmes as having "emerging evidence" for preventing youth violence. Such programmes have been shown to prevent aggression, reduce involvement in violence, improve social skills, boost educational achievement, and improve job prospects. Interestingly, these effects are most significant for disadvantaged or poor children, and the benefits are thought to potentially last into adulthood (World Health Organization 2010).

- An evaluation of **Sure Start Children's Centres** in England found that 3 year old children from deprived Sure Start areas had more positive social development and social behaviour outcomes, compared with children from equivalent areas without Sure Start (and their parents had less risk of negative parenting outcomes). It combined preschool education with parent, childcare and employment support (Bellis et al 2012).

- The **High/Scope Perry preschool programme** in the US targeted children in deprived communities and included home visits and parenting support. A long-term evaluation, which followed participants to age 40, showed reductions in violent crime.

Cost-effectiveness: Researchers estimated the programme to have generated US$17 in savings for every US$1 invested (Bellis et al 2012).

- The **Chicago Child-Parent Center**, another US enrichment programme targeting children in deprived areas, reduced child abuse and violent offending in participating children by early adulthood. It included parent training, outreach services, and ongoing family support.

  Cost-effectiveness: By age 21, the programme is estimated to have saved over US$7 per US$1 invested (Bellis et al 2012).

University/college sexual assault prevention programmes

Although evidence supports some violence prevention programmes in schools, the current literature on the effectiveness of college or university-based sexual violence prevention is more limited. In the US, colleges are legally required to run rape prevention programmes. However, no studies have yet examined the potential effects of campus-based sexual assault prevention programmes on later, campus-wide, incidence of sexual violence (Gibbons 2013).

Still, researchers advocate for campus-based programmes because sexual violence during the university years is so prevalent (e.g. estimated at 20% in the US) and often under-reported (Gibbons 2013). Prevention programmes help to create a safer climate and to increase reporting. Also, changes to knowledge and attitudes are seen as essential steps toward reductions in the actual incidence of sexually violent behaviour (Gibbons 2013).

- **College-based bystander programmes** in the States have increased confidence to intervene, and reports of actual bystander behaviour (i.e. intervening in potentially abusive or violent situations), e.g. the Green Dot project (Gibbons 2013). Increased 'dosage' of the programme was associated with better results – although the lower 'dose' group also showed significant improvements, which suggests programmes can be time-efficient and still achieve positive results (Gibbons 2013).

- US studies of **risk reduction or self defence programmes** in universities have shown short-term reductions in sexual assault of women who were not previously victims of sexual assault, and some empathy-building programmes have achieved a short-term improvement in male attitudes and reduced likelihood of sexual assault perpetration (Gibbons 2013).

- **Rape awareness/attitude change programmes** have been associated with short-term increases in knowledge and improved attitudes, with longer/more frequent programmes the most successful. However, long term changes have not yet been achieved. Single-gender programmes are thought to be more effective than mixed-gender ones (Gibbons 2013).

Consistent with an ecological approach, sexual assault prevention programmes should be accompanied by various other strategies, such as social norms marketing and supportive organisational and student policies to deter sexual harassment and address alcohol misuse (Gibbons 2013).

New Zealand examples of interventions with children and youth

- **Taiohi Morehu** is a community-based project to develop the leadership potential of young Māori leaders, who can then act as catalysts to positively influence behaviour within their

whānau and communities. The initiative started in 2008 with the aim of getting young leaders involved in the "It's not OK" Campaign.

Key reported success factors: It is student-led and includes use of Māori performing arts to promote non-violence as the norm. Reportedly, the Taiohi Morehu project has made a positive impact in communities and supported "huge personal growth" for the rangatahi involved (Ministry of Social Development 2011).

- The **Incredible Years** programme targets child-parent interactions. Positive evaluation data from overseas indicates the programme is effective in other countries. The Ministry of Social Development is currently evaluating the programme in New Zealand.

- More broadly, New Zealand literature suggests that **strengthening educational and employment outcomes** for Māori and Pacific young people are likely valid pathways toward improving health outcomes such as violence (Siataga 2011).

SUMMARY OF CHILD AND YOUTH APPROACHES:

A strong case exists for focusing primary prevention on children and young people, in the context of families and communities. This is backed by sound evidence and theory, with some of the most solid evidence of effectiveness in the field (partly but not exclusively from school-based programmes). A focus on children and youth, in the context of extended families, is consistent with Māori and Pacific perspectives and cultural values.

It is important to target children and young people at risk, including those outside of the formal school system. Some US and Canadian primary prevention programmes have demonstrated success in this area. US evidence supports broad social development programmes and some (mainly school-based) dating violence prevention programmes, but other programmes have only shown short-term effects. Other promising approaches include psychological support for children who have experienced maltreatment, early intervention for children with conduct problems, and pre-school enrichment programmes.

6 Critical success factors for prevention

This last section draws out the core elements associated with effective programmes in this area. Several recent literature syntheses highlight 7 evidence-based success factors for the prevention of sexual violence (Quadara and Wall 2012, Casey and Lindhorst 2009). These are consistent with the literature reviewed that was specific to intimate partner violence and elder abuse. Discussion related to Māori, Pacific, and older people/elder abuse is integrated within these factors below.

1.   Comprehensiveness

Successful prevention uses multi-level, whole-of-community approaches. Multi-level has been defined as using various strategies to target the same outcome, implemented at two or more levels of the ecological model (Quadara and Wall 2012, Casey and Lindhorst 2009). Good practice uses socio-ecological approaches that view violence prevention as requiring interventions that target change at multiple levels, e.g. individual, family, neighbourhood, social institutions, community organisations, public policy, and cultural environment (Shepard 2008).

Integrated, holistic approaches are increasingly recommended. Prevention efforts should incorporate various forms of violence (e.g. child maltreatment, intimate partner violence, elder abuse and community/general violence), making connections between them in terms of causes and solutions (Shepard 2008).

2.   Based on theory of change

Prevention activities need to be informed by both theories about what causes violence, as well as theories of change, e.g. mechanisms of behaviour or community change that are targeted by preventive interventions (Quadara and Wall 2012, Casey and Lindhorst 2009).

A lack of theoretical grounding is a key reason for the limited effectiveness of many prevention programmes in the sexual violence area. Theories of causation and change that are well-supported and considered relevant include: critical gender and feminist theories; ecological theories; indigenous and ethnic-specific theoretical frameworks (e.g. Māori and Pacific models); human rights approaches; social learning theories; crime and deterrence approaches; social-psychological theory; stage of change theories, and cognitive-behavioural theory.

3.   Contextualised programmes

The prevention literature recommends tailoring prevention programmes to specific contexts and communities – known as 'contextualised prevention' – rather than simply replicating existing programmes, without adapting, in new settings. Prevention strategies must be shaped and customised to suit local contexts, where community members are engaged to find out how the community frames the issue of violence, language used, and beliefs about suitable solutions (Quadara and Wall 2012, Casey and Lindhorst 2009). As indigenous researchers argue, prevention strategies must take into account local social and cultural norms and structural issues, e.g. the impacts of colonisation and racism, which relate to violence prevention in communities (Cooper 2012, Victoria Department of Human Services 2012, Powell 2011).

Contextualised prevention is especially vital for preventing sexual violence, because of the deep cultural embedding of attitudes and norms to do with sex and gender, and the diversity of views across religious, ethnic, and community groups. So far, however, culturally and locally tailored strategies are "virtually absent" in the published research on sexual violence prevention (Quadara and Wall 2012, Casey and Lindhorst 2009). Although the literature is sparse, some contextualised programmes created by grassroots groups are widespread, e.g. 'Incite: Women of Color Against Violence' in the US (Casey and Lindhorst 2009).

More broadly, the literature increasingly stresses that prevention efforts need to incorporate, and be adaptive to, diverse experiences and worldviews related to culture, location, ability, sexuality, socioeconomic status, and religious faith (Carmody et al 2009). An emerging theme is the need for populations facing greater risk of violence (e.g. indigenous populations, people with disabilities, refugees) to be involved in the planning and implementation of primary prevention strategies to address violence within those communities (VicHealth 2007).

Importance of cultural grounding

Context-specific prevention approaches are crucial for indigenous and ethnic minority populations. Features consistently highlighted in indigenous and ethnic minority literature include: indigenous-led, use of cultural elements and practices, group face-to-face approaches, development of community

capacity and leadership, and holistic approaches to violence. The use of indigenous and culturally-specific role models and settings are also important (Cooper 2012, Percival et al 2010).

For prevention with indigenous communities such as Māori, researchers stress the need to allow time to build trust and to address the trauma and impacts from structural factors like colonisation and racism (Cooper 2012, Victoria Department of Human Services 2012, Te Puni Kōkiri 2010). Restoring and building community culture is considered to be a protective factor against violence (Shea et al 2010).

Pacific peoples have repeatedly called for violence prevention initiatives that recognise the distinct Pacific cultures (Samoan, Fijian etc.). Percival and colleagues (2010) state that prevention messages for each major Pacific ethnic community in New Zealand should be designed and developed by separate male and female working groups from these communities. This would ensure that key messages are culturally and linguistically accurate, and that campaign materials are provided in the first language using culturally-specific expressions (Percival et al 2010). The use of culturally-specific metaphors in violence prevention materials is also recommended, such as traditional proverbs, humour, and stories.

Holistic paradigms are favoured for effective prevention with Māori and Pacific communities, balancing four domains of wellbeing: physical, psychological, social/family, and spiritual (Cooper 2012, Siataga 2011). Research recommends integrated prevention packages combining the prevention of violence and alcohol and drug misuse with the promotion of mental and physical health and safety (Percival et al 2010). Cultural competence training for those working on family violence issues with Māori, Pacific and migrant and refugee communities is also recommended (e.g. Boutros et al 2011).

4.   Positive, strengths-based approaches

Another key success factor is the use of strengths-based approaches like cultural strengthening, whānau ora, positive youth development, and promotion of skills development to enhance protective factors (as opposed to avoidance of risk factors). Alongside individual development, there is a strong emphasis on the development of health-promoting environments and supportive social contexts, as this will help to sustain individual behaviour change (Casey and Lindhorst 2009).

Māori and Pacific research in New Zealand aligns with positive approaches, such as focusing on building healthy and balanced relationships and strengthening families, rather than on victims and perpetrators (Victoria Department of Human Services 2012, Cooper 2012, Grennell and Cram 2008, Percival et al 2010, Te Puni Kōkiri 2009).

Positive approaches have the advantage of influencing more people in a community (not just those at highest risk), as wellbeing and access to resources for all people is enhanced. Examples include positive and healthy sexuality education, opportunities for men and boys to form respectful relationships with women, and with positive male role models, empowering climates that explicitly celebrate and reward non-violent norms, and bystander interventions (Casey and Lindhorst 2009).

5.   Community-driven

Community-led prevention may include: engaging community members in setting priorities and developing strategies for change; partnering with community-based groups; and supporting community members to take on leadership/advisory roles and to deliver interventions. Community engagement is known to increase the longer term sustainability of prevention projects, so they can continue after formal funding has ceased (Casey and Lindhorst 2009). However, ongoing funding remains important to support and sustain community-level collaborations.

Community ownership and engagement is critical for prevention in indigenous communities. In particular, overseas and New Zealand indigenous literature underscores the need for engagement with kaumatua or indigenous elders, and with men as well as women and children (Cooper 2012, Victoria Department of Human Services 2012, VicHealth 2007). Another theme is the importance of encouraging intergenerational interaction and collaboration within preventative work, e.g. work that involves greater interaction between elders and young people.

Indigenous literature also highlights the need for long-term, sustainable approaches, capacity building and skill development, improving access to resources and support systems, and the use of partnerships between and among community and government agencies.

6.   Addressing structural factors

Effective prevention works to change underlying social structures such as gender discrimination, inequality in political representation or health status, social norms sanctioning rape, and the impacts of poverty and racism (Casey and Lindhorst 2009, World Health Organization 2002). This is because individual actions are reinforced and constrained by social-structural factors. The gender-based violence field has long theorised that underlying social-structural factors contribute to violence against women (Casey and Lindhorst 2009).

7.   Incorporating impact evaluation

While acknowledging the challenges of evaluating prevention initiatives, especially complex and multi-level initiatives that seek transformative social change, the literature highlights the need for evaluation of the impact of prevention (Quadara and Wall 2012, Point Research 2010).

In New Zealand's "It's Not OK" campaign, both internal and independent evaluation has been widely used to examine both national and local impacts – and allowed insight into the social context of family violence and how effective behavioural change is facilitated in *specific* communities. Using an action-reflection model, this knowledge is then used to inform aspects of the campaign, based on the needs of various communities (Point Research 2010). This helps to create contextualised interventions.

Other evidence on success factors

Success factors identified in the literature on bystander interventions are largely congruent with the above factors above. A specific factor highlighted in relation to bystander programmes is the importance of gender-specific design (Powell 2011). This involves applying gendered analysis to the design and development of programmes and tailoring strategies to men and boys in particular.

However, researchers suggest that delivery should comprise *both* single-sex and mixed-sex programmes. This is because some evidence suggests that mixed-gender groups may be more effective in changing male behaviour, whereas for women single-sex groups appear to have more success (Powell 2011). Skilled and supported programme facilitators are also emphasised.

A recent review of evidence in family violence and older adult abuse fields (not specific to primary prevention) concluded that key attributes of successful initiatives were: the use of coalitions; coordination of and sharing of resources; approaching family violence and elder abuse from a lifespan model that empowers individuals and fosters citizen engagement; and fostering political champions (Norris et al 2013).

The 'It's Not OK' campaign has highlighted various success factors, broadly consistent with the generic factors given above. The positive and multi-layered, integrated approach is seen as important, as well as the use of genuine role models and real stories which people find believable (Point Research Ltd 2010).

7 Conclusion

This review has explored two broad areas:

1) the latest international and New Zealand evidence on preventing intimate partner violence and elder abuse before it occurs (including effective and promising examples), and

2) the latest thinking on why particular approaches are effective or promising, as well as common elements of effective programmes.

1. *What works to prevent partner/elder violence before it occurs?*

Worldwide, it is early days in the field of researching the primary prevention of intimate partner violence, and particularly for sexual violence and elder abuse. In New Zealand, most primary prevention programmes are not yet evaluated, so their current effects cannot be known for sure.

However, evidence is emerging and much promising work is underway locally and internationally. Researchers say there are other grounds for supporting prevention interventions while the field is under-evaluated, e.g. where they are theoretically sound, feasible, successfully implemented, and where they fully address known risks and protective factors (Bellis et al 2012, World Health Organization 2010, VicHealth 2007).

Our review focused on five types of interventions (societal, community, indigenous, alcohol-related, and children/youth). We identified evidence of effectiveness for each approach, however this does not mean that *all* such interventions are successful. Many interventions are under-evaluated, especially in the areas of indigenous prevention and broader interventions at community and societal levels.

Despite the gaps in knowledge, international researchers and public health experts say that all five reviewed approaches have good promise. Important concepts to stress are: fidelity of implementation of good programmes (i.e. implemented as intended); sustainable implementation and support of programmes; and comprehensiveness to ensure that population-level gains can be made.

The generic literature is often silent on the prevention needs of indigenous peoples, as well as those in ethnic minority groups. Researchers agree on the need to tailor prevention strategies to suit local contexts though, especially cultural and ethnic needs and priorities.

In particular, Māori-led approaches and partnerships should be resourced, supported, and evaluated in New Zealand. Whānau violence is more broadly defined than non-indigenous family violence (using a wider definition of family), and requires different prevention strategies to reflect this. Indigenous literature suggests that addressing the impacts on Māori of structural inequalities, colonisation, and racism should be an integral part of primary prevention (Cooper 2012, Victoria Department of Human Services 2012).

Overall, this review located very little information on the primary prevention of elder abuse and neglect, as the research base and practice are at an even earlier stage than intimate partner and sexual violence.

Very few primary preventions targeting elder abuse or neglect have been implemented worldwide (Norris et al 2013, Daly et al 2011, World Health Organization 2010, Bagshaw et al 2009).

Researchers in the elder abuse field stress the need to address ageism as an underlying contributor to elder abuse and neglect. Advice includes transformative interventions that work to change social norms, participatory and empowerment models, culturally-specific responses, reducing alcohol-related harm, and reducing family and caregiver stress. As well, researchers advocate for more collaboration between the intimate partner violence and ageing sectors (Bagshaw et al 2009).

2.   *What has the best chance of success?*

Broad principles

International experts agree that primary prevention is urgently needed (World Health Organization 2013, Quadara and Wall 2012, VicHealth 2007). Primary prevention literature is united on the need for holistic, collaborative, and whole-of-community approaches to change influential social and gender norms that affect partner and elder violence. Ecological approaches are widely used and accepted internationally – to understand the multiple, interacting causes of violence, as well as informing strategies for primary prevention.

The life-course perspective supports a strong focus on children and young people, as the target group with the best potential for significant prevention of violence before it occurs (World Health Organization and London School of Hygiene and Tropical Medicine 2010). Children and young people exposed to violence in their families warrant concerted prevention efforts because of the greater risk of future perpetration or victimisation.

A core theme is the importance of *contextualised* prevention programmes, where approaches are designed to suit local cultural and community contexts. To be effective, prevention strategies must be informed by local community members and the unique cultural and social needs and preferences of particular communities. This is crucial in indigenous communities. Indigenous researchers say the approaches most likely to have success include: strengths-based and community development approaches, cultural and family strengthening, partnerships between indigenous communities and various agencies, and focusing on alcohol and drug use, as well as children and youth at risk.

The literature also recommends particular strategies – emphasised more in recent years – for the primary prevention of partner and elder violence, e.g. strengths-based, positive approaches (like positive youth development or iwi-led development focused on strengthening whānau) and targeting men and boys in violence prevention. These broadly align with Māori and Pacific models of wellbeing and violence prevention.

Suggestions for action

The advice from researchers internationally is clear: we know enough about promising and likely effective strategies to put these into practice – with evaluation of the impacts to deepen our understanding of what is working, who for, and why. The World Health Organization and London School of Hygiene and Tropical Medicine (2010) are persuasive in their argument:

> Although pressing, the need for evidence and further research in all these areas in no way precludes taking action now to prevent both intimate partner violence and sexual violence. Those programmes that have evidence supporting their effectiveness should be implemented

and, where necessary, adapted. Those that have shown promise or appear to have potential can also play an immediate role – provided strenuous efforts are made to incorporate at the outset rigorous outcome evaluations.

It is only by taking action and generating evidence that intimate partner and sexual violence will be prevented and the field of evidence-based primary prevention of such violence will successfully mature (World Health Organization and London School of Hygiene and Tropical Medicine 2010, p2).

In the spirit of "taking action now", we suggest these next steps for primary prevention in New Zealand:

1. Develop a national framework for the primary prevention of family violence.

2. Continue to resource, support, and evaluate the impacts of existing promising programmes in New Zealand, e.g. the 'It's Not OK' campaign, 'E Tu Whānau!', and 'Pasefika Proud' campaigns.

3. Prioritise the development and expansion of primary prevention strategies at community and societal levels, aiming to change social and gender norms. Important community and/or societal approaches highlighted in this review include:

   • Māori-led and Pacific-led strategies that encourage community and societal-level change

   • community development and positive youth development aiming to improve various outcomes, including all forms of violence

   • primary prevention focused on men and boys in the context of families, whānau, and communities

   • changes to policies and legislation to reduce alcohol-related harm in general, and

   • multi-agency, cross-sector primary prevention strategies that take an integrated approach to violence and target change at community and societal levels.

4. Explore the potential to adapt successful primary prevention programmes from overseas to a New Zealand context, beginning by piloting programmes that have been evaluated as effective.

5. Build on this review to identify more specifically the most effective content and delivery strategies for primary prevention programmes.

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