What Works

Social Policy Evaluation and Research Unit

What works for children exposed to family violence?

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This *What Works* synthesises international evidence with information about current services provided in New Zealand for children exposed to family violence. It makes recommendations for policymakers directing new investment, and for practitioners delivering services for these children.

International evidence shows that the best interventions for children exposed to family violence:

- include therapeutic work for both children and their non-abusive parent
- focus on strengthening relationships between children and their non-abusive parent
- are informed by knowledge about how trauma affects children
- address each child's individual needs
- are delivered as early as possible and by highly qualified staff.

We surveyed New Zealand's current providers of services for children exposed to family violence and found that interventions focus on advocating for children's needs, and educating children and parents about violence and its effects. Services offer a safe space for children to be heard and are perceived as approachable by clients. Specific activities such as practical tools, resources and therapeutic activities are particularly valuable.

About *What Works*

Superu's *What Works* series synthesises what we do and don't know about a specific social sector topic. We draw on international and New Zealand research to identify what does and doesn't work to address the topic at hand. Our aim is to inform decisions and investment in the social sector.

Exposure to family violence is just as harmful as direct physical abuse, but current responses target direct physical abuse only.

Current responses in New Zealand are targeted at children who are direct victims of physical abuse, with no differential response for those who are exposed to violence in other ways. Interventions for children exposed to family violence are crucial for interrupting intergenerational patterns of violence[1] and creating long-term change. The present political context of social investment and the establishment of the Ministry for Vulnerable Children – Oranga Tamariki presents an opportunity to establish new evidence-based interventions in New Zealand for children exposed to family violence.

How can we best help children exposed to family violence?

Policymakers focused on families:

- For greatest impact, increase access to specialist therapy services.
- Support organisations to focus their interventions on therapy and parenting skills delivered to both children and non-abusive parents/caregivers.
- Ensure services are delivered by highly qualified staff who understand how trauma impacts children's functioning.
- Support the integration of family violence services across the system.
- Establish graded levels of response and a system of intervention for *exposure* to violence, not just physical abuse.

People working directly with families (practitioners, service providers, agencies):

- Tailor services as best you can to the individual needs of different children and families.
- Include parenting skills training in your programmes wherever possible.
- Work with funders to build your organisation's ability to generate evidence about your programmes.
- Maintain a network with other service providers in your area to link services and share resources.

Background

This section summarises information about the context of child exposure to family violence in New Zealand, including prevalence, impacts and moderating factors.

What do we mean by 'exposure to family violence'?

Exposure to family violence can include seeing, hearing, being directly involved in (eg trying to intervene), or experiencing the aftermath of family violence.[2–5] The term *exposure* is used in preference to others (eg *witness, observe*) because it includes indirect experiences as well as direct observation. *Experiencing* violence is a term generally used to emphasise children's subjective perspectives.[6]

Family violence is a broad term used to describe physical, sexual and emotional or psychological abuse both of and by children, parents, elders, siblings, and intimate partners.[7] This *What Works* summarises research on family violence and other types of violence which falls under this definition, such as *domestic violence, intimate partner violence* and *child maltreatment*. However, most research describes violence where a male (usually a child's father and/or their mother's partner) perpetrates violence against a female (usually the child's mother). There may also be reciprocal aggression between parents, which increases the likelihood that children will suffer physical abuse. In many cases, intimate partner violence overlaps with other forms of family violence such as child physical abuse, although exposure to any kind of family violence in itself constitutes emotional abuse.

In this document we use the term *parents* to also include caregivers. Our use of the term *children* includes anyone up to 18 years old.

Exposure to family violence can include seeing, hearing, being directly involved in (eg trying to intervene), or experiencing the aftermath of family violence.

Most family violence offences in New Zealand occur with children in the household

It is not possible to accurately estimate the prevalence of children's exposure to family violence in New Zealand. Existing data is limited by underreporting of family violence in general, underestimation of children's exposure to family violence, and a focus on the main victim of family violence in existing data collection mechanisms. However, 70% of family violence offences in New Zealand take place while there are children in the household.[8]

Recent data indicates that in the previous year, 14% of children in New Zealand witnessed adults at home physically hurting other adults and/or children, and almost half witnessed adults yelling or swearing at each other.[9] These figures are consistent with international data.[10] Reports from young people show that at least 40% have witnessed at least one violent act by a parent,[11] mostly before age 11.[12] On the other hand, only 3% of mothers in the Growing Up in New Zealand study report that their children regularly witness arguments (including episodes of physical violence) between parents.[87]

70% of family violence offences in New Zealand take place while there are children in the household.

Figure 1: About 70% of children who are exposed to family violence are also direct victims of physical abuse

30% of children who are exposed to family violence do not receive adequate support services.

Although children exposed to family violence are often also victims of abuse, exposure is just as harmful as direct physical abuse.

Figure 1 shows how children who are direct victims of physical abuse are a subset of those who are exposed to family violence. While this subgroup is undoubtedly important and requires specialist intensive support, the wider group of children exposed to family violence comprises both these children and many more. Consequently, interventions for children exposed to family violence apply to both groups.

Child witnesses of family violence are also victims of physical abuse in approximately 70% of cases,[9] and the presence of violence in the home means that children are at greater risk of being physically abused,[13] especially if the violence is bi-directional between parents.[7]

We are becoming more aware of the prevalence of exposure to violence, with changes in reporting behaviour contributing to a 47% increase in notifications of emotional abuse (which in part reflect child exposure to family violence) from 2006 to 2012.[14]

Children who witness an adult being the victim of violence lose trust in both the perpetrator's and the victim's capacity to protect them from harm. They struggle to feel physically and psychologically safe.[15] This lack of protective safety impacts their functioning across a range of domains. Children themselves have reported that witnessing adult violence at home is more distressing than being directly physically harmed by adults,[11] and that witnessing physical or emotional violence has a greater impact than experiencing the violence directly.[16]

Exposure to family violence impacts children via direct and indirect routes, which ultimately lead to outcomes which are as severe as those for children who have been victims of direct physical abuse.[17] Direct impacts include learning responses such as aggression and the effects of violence such as family stress.[18] Indirect impacts have an effect on children through secondary mechanisms such as reducing the non-abusive parent's capacity to parent effectively, which then has flow-on effects to a child's functioning.[18]

Minority populations are more likely to be exposed to family violence

Research with New Zealand secondary school students shows that those of Pacific ethnicities have the highest rate of exposure to family violence, followed by Māori and Asian ethnicities.[19] Migrant, refugee, and immigrant populations in New Zealand are also more negatively affected by family violence than Pākehā, because they don't have as many options to improve their situation.[20] There is little research on how the experiences of Māori tamariki differ from those of Pākehā children, or for those of Pacific families, other ethnic minorities, refugees, and disabled children.[9]

Children who are exposed to family violence are more likely to: be depressed and anxious, attempt suicide, display aggression and lash out at others, be traumatised, and be victims or perpetrators of future violence

Children exposed to family violence are more likely to experience problems such as depression and anxiety[2,11,21] than those who aren't exposed to family violence, and are more than four times as likely to have attempted suicide.[22] Children exposed to family violence are also more likely than those that aren't to develop conduct disorder and display aggressive and antisocial behaviour.[23]

Children who are exposed to violence live in an environment of fear, which means they are constantly on edge and are more likely to experience post-traumatic stress disorder, and have difficulties processing emotion and making decisions.[2,24]

Exposure to family violence is also associated with below-average self-esteem, higher chances of being the victim or perpetrator of violence in adulthood,[11] and beliefs that violence is justified and that violence enhances boys' self-image.[25]

Exposure to family violence has greater impacts for: younger children, those who are victims of physical abuse, and those who are dealing with other additional stressors

The impact of exposure to family violence can be even worse for children who experience additional risk factors. First, age has an established effect. Being younger tends to be associated with worse outcomes and more severe impacts,[25,26] and the earlier and more prolonged the exposure, the more severe the impacts.[27] Impacts vary depending on age also: pre-schoolers tend to display behavioural, social, self-esteem, and psychosomatic problems; school-age children have difficulties with school performance and social functioning, and may display more externalising behaviours; adolescents have problems with social functioning and identity formation.[27,28]

Second, the impact of exposure to family violence may also differ depending on the gender of the child. Although overall distress is the same for boys and girls,[12,29] the effect on externalising problems (eg aggressive behaviour) may be particularly strong for boys.[2] Boys tend to externalise and girls internalise,[30] but both are susceptible to bullying and intimidation.[31]

Third, there is some evidence of a 'double whammy' effect whereby children who are both exposed to violence and the victims of physical abuse (ie the subset displayed in Figure 1) experience worse outcomes than those who are either victims or exposed to family violence (but not both). This is particularly true for internalising problems such as depression.[28,32]

Fourth, children exposed to family violence are more likely to experience other stressors such as poverty,[33] and research suggests that these additional risk factors relate to impacts of depression, suicide attempts, drug abuse, nicotine dependence, and violent crime; while the family violence itself relates to problems with anxiety, conduct disorder, alcohol dependence, and property crime.[33]

Children who witness an adult being the victim of violence lose trust in both the perpetrator's and the victim's capacity to protect them from harm. They struggle to feel physically and psychologically safe.

Good relationships with family members help protect children

Family dynamics and the presence of others can help buffer the effects of exposure to violence. Effective parenting is associated with better outcomes in children exposed to intimate partner violence.[34] Adolescents who are in stable and socially connected households tend to fare better than others.[25] Resilience is promoted by a good relationship with their non-abusive parent, having other social supports available, and having positive sibling and peer relationships.[27] The presence of siblings can influence whether the child takes on a protective parenting role over the other siblings, which then impacts on how the violence affects their functioning.[35]

Children's **resilience** is promoted by a **good relationship** with their **non-abusive parent**.

Interventions for children exposed to family violence generally reflect four types, however the way they are delivered can vary

Psychotherapy is an umbrella term that encompasses both cognitive-behavioural therapies (CBT), and other types such as play therapy, art-based or expressive therapies. Content varies according to sub-type and characteristics of the participant(s) such as age. Psychotherapy works by establishing a relationship between the therapist and client that helps the client overcome difficulties.

Parenting skills training aims to improve parents' (almost universally mothers' or non-abusive parents') capacity to parent effectively by strengthening their abilities to support their children, manage their behaviour, and maintain positive relationships with them.

Psychoeducation for children involves increasing children's knowledge about family violence and their responses to it. Various components of psychoeducation include safety planning, communication and conflict resolution skills, self-esteem, stress management, knowledge about gender, and understandings of violence.

Advocacy interventions involve promoting children's needs through representation in different agencies, ensuring the availability of appropriate services, and facilitating referral processes. Advocacy is commonly carried out by caseworkers in crisis services such as women's refuges.

All four types of interventions can be delivered as either the primary component of a programme or in combination with other types. Interventions can also be delivered to children, parents, or both together. In some cases, different types may be appropriate for members of the same family or whānau (such as psychotherapy for children and parenting skills training for non-abusive parents).

What are we already doing? Current New Zealand responses

International evidence provides valuable information about the effectiveness of different types of interventions, but in order to successfully apply the findings in New Zealand, they need to be considered in relation to the current local context. Accordingly, we asked service providers about the programmes they deliver for children exposed to family violence, and about their views on the current state of service provision in New Zealand. We acknowledge that although this evidence provides valuable context for new service provision, it represents the views of providers and may not necessarily correspond to children's voices or to the international evidence.

Children's needs are not fully addressed by current family violence services

Despite service providers accepting referrals from a variety of sources, there are actually only two main pathways by which children exposed to family violence commonly gain access to services: referrals by police who attend a family violence incident at which children are present, or reporting by school staff.[36] This means that any children who do not have contact with police or capture the attention of school staff may not receive access to services. Many services may also not be accessible without the cooperation of a parent, meaning that children's needs are addressed as secondary to those of the victim rather than in their own right.[36]

Of the two pathways available, the primary one (ie police notification) occurs only after violence has escalated to the point at which police are involved. This reflects a current focus on high-risk situations where children are at immediate risk, and less emphasis on services for children whose exposure to violence is of perhaps lower intensity but has equally negative impacts.[37,38] In many cases, children will escape the situation only by becoming old enough to extricate themselves – at which point the damage is already done.[39] Preventing exposure to family violence is necessary to interrupt intergenerational patterns of violence.[1]

We surveyed New Zealand organisations who provide services for children exposed to family violence

To understand what services are currently being delivered in New Zealand for children exposed to family violence, we administered a survey to 146 potential service providers (such as women's refuges, community counselling agencies, and violence prevention services) throughout New Zealand. Fifty-two service providers were identified through funding records from the Ministry of Social Development, and 94 via independent research.

Of the 146 agencies, 57 completed the survey, a response rate of 38% .* Of these 57 valid responses, 65% stated that they delivered a specific intervention for children exposed to family violence. A further 19% did not deliver a specific intervention for children exposed to family violence, but did see them as part of their clientele. Sixteen percent of service providers did not interact with children exposed to family violence and were therefore excluded from further analysis.

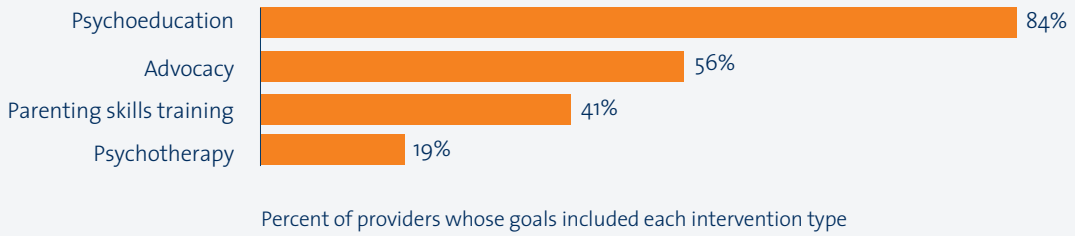
Often, programmes were not specifically for children exposed to family violence but were also targeted at child victims of family violence (81%), adult victims of family violence (41%), adult perpetrators of family violence (16%) or others (such as those which were part of a holistic whānau service; 19%). One-quarter of the programmes were delivered in a group format, 40% were delivered in an individual format, 31% were delivered in either group or individual formats depending on case-specific factors, and 10% were delivered in a whānau-based format (eg sibling groups).

Most programmes took referrals from a variety of sources, including self-referrals (88%), Child Youth and Family (81%), courts (69%), police (69%), and schools (49%). Programmes were also funded from a variety of sources, including Ministry of Social Development (88%), Ministry of Justice (56%), Ministry of Health (6%), Whānau Ora (6%), and others (25%) such as philanthropic societies, local councils, and public fundraising.

* In reality, not all of the 146 agencies would have been delivering services for children exposed to family violence to begin with, and so the percentage of providers who do provide these services and who responded to our survey is likely to be higher than 38%. However, we acknowledge that these results reflect only those service providers who responded to the survey, and that the views of non-respondent service providers may differ.

The goals of current services for children exposed to family violence focus on psychoeducation and advocacy

Figure 2: Goals of current programmes for children exposed to family violence



We asked service providers about their programmes' goals, and used their responses to categorise the interventions into types. Results are displayed in Figure 2. Most providers (84%) had goals which related to psychoeducation for children, and 19% had goals solely related to psychoeducation. These goals included *"ensure their knowledge around things like responsibility for violence are accurate"*, *"helping children understand protection orders"*, *"learn skills of empathy"*, *"teach them skills like talking about and sharing feelings"*, and safety planning, eg *"to help the child understand ways they can keep themselves safe"*.

Over half of the providers (56%) included advocacy services in their interventions – typified by goals such as *"allow our kids to have a voice"* and *"to identify any children who may require further expert intervention"*.

A smaller proportion of providers (41%) had goals that related to parenting and children's relationships with their parent(s), such as *"the teacher models peaceful interactions between herself and the children, to the parents"*; *"children and the victim begin to rebuild their relationships, and/or their attachment/bond, which is often damaged as a result of family violence"*; and *"to create healthy family environments that are conducive to children's wellbeing and development"*.

Still smaller (19%) was the proportion of providers who explicitly mentioned goals relating to cognitive-behavioural therapy, trauma-informed practice or other types of psychotherapy, eg *"structured educative skill based programme that focuses on emotions and thoughts about family violence in the home"*, *"counselling... to work through trauma"*, *"trauma processing"*.

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Service providers' strengths include creating a safe space for children to talk

Figure 3: What service providers think are the key things that make a difference for children exposed to family violence

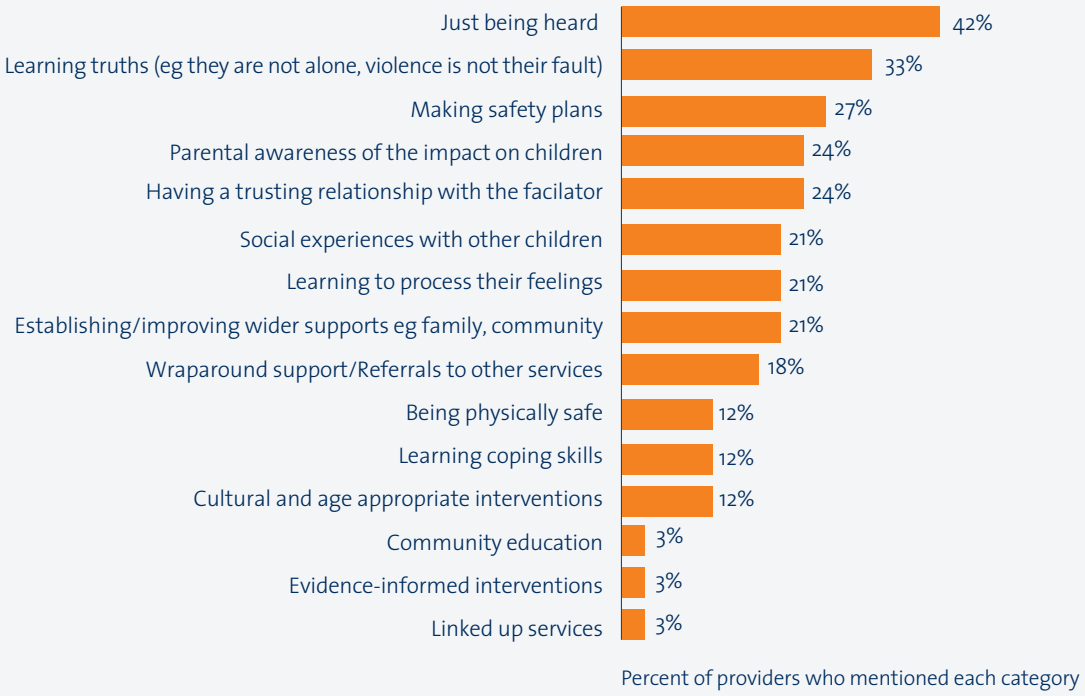
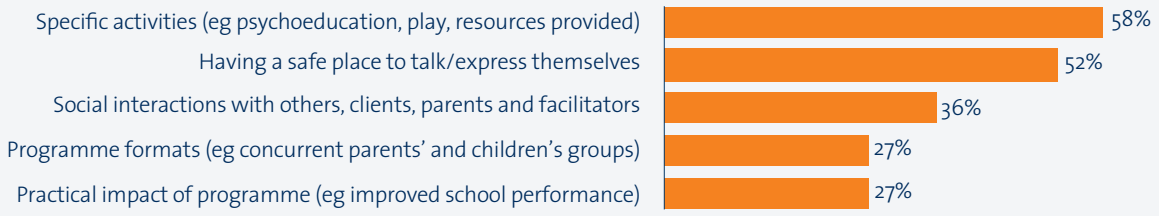


Figure 3 shows what services providers think makes the biggest difference for children exposed to violence. Providers most often said that children need to be heard and have a place to talk about their experiences (42%). Providers also mentioned that children learn lessons such as they (children) are not to blame, that they are not alone in their experiences, and that they are not responsible for adults' behaviour (33%), as well as making safety plans (27%).

Other points mentioned by providers included ensuring that parents are aware of children's experiences (24%), building a trusting relationship between children and the programme facilitator (24%), providing children with fun social experiences (21%), helping children to express and address their feelings (21%), and establishing wider supports for children by increasing parental capacity and strengthening whānau and community supports (21%).

Clients of service providers value the specific programme activities (eg play, resources, education about violence)

Figure 4: What service providers say their clients find most valuable about their programme



As displayed in Figure 4, over half of the providers (58%) stated that clients find the **specific activities** of their programme the most valuable aspects, eg *"tools and plans for increasing safety"*, *"they love the fun they have using art therapy, enjoy the food and celebration we hold for them at the end of the programme"*, "*the games and activities*", *"extra support such as provision of produce and foodstuff"*, *"learning they are not responsible for adult behaviour"*.

Approximately half (52%) also mentioned that the presence of a **safe space to talk** was important, for example *"clients are able to talk freely in a safe forum with no judgement"*, *"having a voice"*, *"being able to share their stories and experiences"*.

Providers also mentioned the **social interactions** built in their programme as important (36%). This included interactions with other participants (eg *"being with others who have experienced something similar"*), programme facilitators (eg *"trusting relationship with the facilitator/educator"*), and parents (eg *"having the support of their parent/caregiver"*).

Aspects relating to the **format of the programme's delivery** were less frequently mentioned (27%) but covered a range of responses, such as "it is *holistic and it provides a wraparound support for the whole family"*, *"delivered by Māori for Māori"*, and *"programme running at the same time for their parent/guardian so that they know what the child's programme is all about"*.

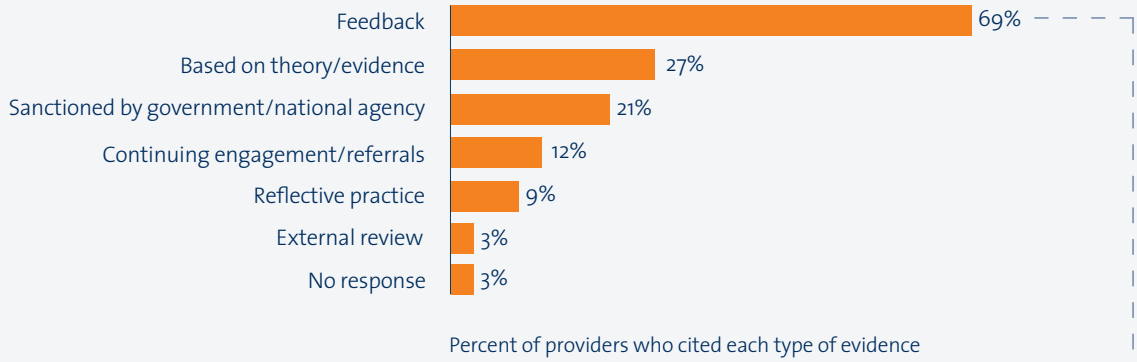
Similarly, 27% of the providers mentioned important aspects relating to the **practical impact** of the programme, such as *"what they do with us they can use in their homes"*, "*children becoming more outgoing... and able to learn at school*", and *"children tell us they feel safer, less anxious, more connected to their parents"*.

Evidence about New Zealand programmes is promising and needs to be built further

Of those service providers who delivered a programme for children exposed to family violence and completed the survey, 21 (57%) had had their programme evaluated. However, only two providers were able to share their evaluation with us.* Through independent research, we identified a further four evaluations of New Zealand programmes.

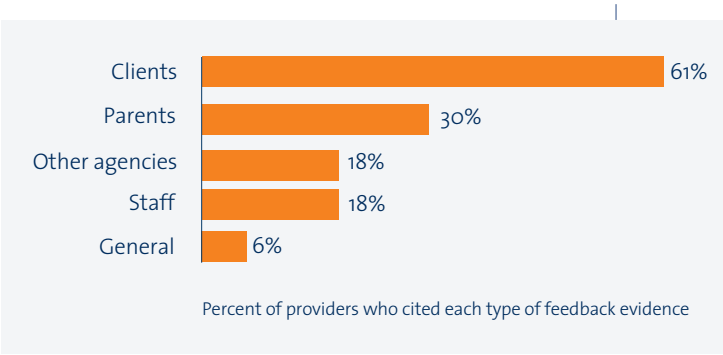
We used Superu's Evidence Rating Scale to assess the evaluation evidence about these six evaluations (representing five New Zealand programmes). These evaluations all met level 2 criteria for the strength of evidence ("progressing, some evidence"), and showed beneficial effects, resulting in ratings that the programmes should be continued. You can find Superu's Evidence Rating Scale at **thehub.superu.govt.nz/superu/evidence-rating-scale**

Figure 5: Service providers' sources of evidence about the effectiveness of their programmes



We also asked providers what evidence (other than evaluations) they had about their programme's effectiveness, and these responses are displayed in Figure 5. The most common form of evidence, cited by 69% of providers was feedback: from clients (61%), parents (30%), staff (18%), and other social service agencies (18%). A smaller number of providers stated that their programme was based on an underlying theoretical approach and/or evidence from international literature (27%). Other responses included that the service was a regional subsidiary of a national agency or sanctioned through receipt of government funding (21%), clients engage/referrals continue to be received (12%), staff engage in reflective practice (9%), and the service has undergone an external review (3%). Only three providers (9%) explicitly mentioned pre- and post-programme measurements of results.

Figure 5a: A close view of feedback types



* Reasons for this low response are likely due to a combination of factors, including lack of access to documentation, misunderstanding about what constitutes an evaluation, and lack of capacity to conduct evaluations across the community and voluntary sector.

What works? International evidence

This section summarises international evidence about what interventions work for children exposed to family violence. Evidence primarily reflects that discussed in the most recent reviews on the topic, which are focused on randomised controlled trials of manual-based interventions conducted in the United States of America, with a small number of evaluations from Australia, the United Kingdom, Sweden, Canada, Israel, and the Netherlands.

First, we use Superu's Evidence Rating Scale to assess the international evidence about different types of interventions, then we discuss the evidence in more detail. Superu's Evidence Rating Scale provides a rating for international evidence based on a combination of the evidence about an particular intervention's effectiveness, and the strength of that evidence. Table 1 shows recommendations about each of the intervention types covered in this *What Works*, based on the effectiveness and strength of evidence descriptions from the Evidence Rating Scale.

Table 1: Recommendations for different intervention types based on Superu's Evidence Rating Scale

Intervention type	Effectiveness	Strength of evidence	Recommendation
Psychotherapy: CBT	Beneficial	4 Well supported, large scale	Extend
Other types	Beneficial	2 Progressing, some evidence	Extend
Parenting skills training	Beneficial	2 Progressing, some evidence	Extend
Psychoeducation	Mixed	2 Progressing, some evidence	Maintain
Advocacy	Mixed	2 Progressing, some evidence	Maintain

Strength of evidence scale

0	Pilot initiative
1	Early stage, good in theory
2	Progressing, some evidence
3	Good evidence
4	Well supported, large scale

Psychotherapy and parenting skills training have the greatest impact; there is less evidence in support of psychoeducation and advocacy interventions

The evidence for some psychotherapies for children (such as play therapy, equine therapy and expressive writing therapy) tends to be vulnerable to methodological limitations, but does show some positive impacts on behaviour.[40] However, other psychotherapies (particularly CBT) have a wealth of robust evidence such as randomised controlled trials behind them, and generally show positive effects on many behavioural and emotional outcomes for children of various ages.[41]

Interventions to improve non-abusive parents' parenting skills are supported by a moderate amount of evidence, of varying strength,[40,41] when they are administered as a single intervention or in combination with psychotherapy for the children.[40]

The evidence regarding psychoeducation for children is mixed and subject to some potential biases, showing support for a positive impact on children's behavioural problems and coping skills in some studies,[40] but no effect in others.[41,42]

Evidence regarding advocacy services for children shows few positive effects on children's outcomes,[42] however there is more support for advocacy when it is combined with other interventions such as parenting skills training for non-abusive parents and psychotherapy.[40,41,43] In general the strength of the evidence for advocacy is limited by issues such as small sample size and lack of comparison groups.[40,41]

The evidence from controlled trials for all types of interventions in the review covered here was mixed and potentially vulnerable to issues of bias. This means that definitive overall conclusions cannot be drawn.[41] They also highlighted limitations of the trials reviewed, such as not reporting the technical aspects of implementation or how an intervention leads to change. There were also no identified trials of interventions (of any type) for adolescents above the age of 14.

The most effective interventions are delivered to both children and their non-abusive parent.

Interventions have the greatest impact when delivered to children along with their family, whānau and community

In addition to categorising the evidence according to intervention type, other research has examined the evidence for different target populations, most commonly mothers (as the non-abusive parent), children, and both mothers and children treated together. While consistent robust evidence for various types of interventions across different groups is lacking,[41] existing evidence generally suggests that the most effective interventions are delivered to both children and their non-abusive parent rather than either group alone – regardless of what type of intervention is actually being delivered.[40,43–47] Repairing the damaged relationship between children and their non-abusive parent is crucial to re-establishing a secure base from which the parent can parent effectively and children can recover from their experiences.[47–49] For example, one study found that an intervention for children was effective on its own, but even more so when delivered in combination with parenting support for children's mothers.[18]

Regarding psychotherapy interventions specifically, individual work with children only can also be helpful for a range of outcomes including internalising and externalising problems.[40,43] Group-based psychotherapy can be effective for specific sub-populations of children such as adolescent boys.[43,50] However, individual therapy is best suited to those children who have been impacted more severely by exposure to family violence[43,46] or who have symptoms – such as shallow social contact – which limit their ability to participate effectively in groups.[51]

Repairing the damaged relationship between children and their non-abusive parent is crucial.

Internationally, interventions delivered to wider groups such as whole families, whānau, or communities are comparatively sparse and have generated little robust evidence. These interventions can be particularly helpful (and are in fact necessary) for indigenous people as they help heal not only the children but other family and community members,[52] and address family violence in the context of colonisation and other traumas that indigenous children may face.[52,53] Some family and whānau-based programmes exist in New Zealand (eg He Taonga Ngā Mokopuna) and show beneficial effects.[43] Approaches to whānau violence will need to reflect the differences between whānau and family, and to address the complex factors which underlie family violence for Māori.[54] None of the international evidence reviewed examined programmes which included children's fathers who were the perpetrators of family violence.

Interventions need to be tailored to individual children and informed by knowledge about the effects of trauma

It is important for interventions to be informed by knowledge about trauma and how this affects children, given that children exposed to family violence are at greater risk of experiencing physical abuse and experience a range of other traumas and stressors.[44,47] CBT which incorporates trauma-focused aspects has been shown to be more effective for reducing anxiety and trauma symptoms than other forms of CBT and psychotherapy in general,[41] and is particularly important for indigenous children who are more likely to have experienced multiple traumas.[44]

Interventions also need to be tailored for the appropriate age and developmental level of each child. The impacts of exposure to violence manifest differently for children of different ages, and children possess different ways of expressing their needs.[18] Consequently, interventions will have greatest impact when designed with these specific factors in mind.

Interventions can affect children differently depending on their difficulties and personal qualities. Children who are at greatest potential risk for negative outcomes broadly tend to benefit the most from interventions, and those who have multiple other risk factors (such as more prolonged or severe exposure to family violence, poverty, parental stress) show the greatest improvements following intervention.[51] Children who have a limited ability to identify and control their emotions tend to improve earlier in treatment, whereas those with greater emotional control improve only at the end of treatment.[55] Positive self-esteem can also be a protective factor.[17] Interventions need to be tailored to the different qualities of individual children.[56]

The earlier the intervention, the better

Because the impact of exposure to violence worsens over time,[26] earlier interventions are likely to lead to better outcomes and reduce the likelihood of later impacts. Interventions before age 7 result in the best outcomes,[24] and the earlier the better.[57] This is consistent with the current social investment approach in New Zealand, of intervening early to prevent future negative impacts. When children are living in refuges, interventions can be administered at an early stage, and there is some evidence that these can reduce behaviour problems in children.[43]

School-based interventions offer a number of advantages by virtue of their universal context, such as the capacity to raise awareness, provide support, and be a safe and neutral place for children to grow and develop.[53] Initial evidence about the effectiveness of school-based programmes shows some promise,[44] although robust evidence has yet to be established.

Digital services for children and young people are emerging and are a promising means of engagement, although little evaluation has been undertaken, especially for the topic of exposure to family violence.[43,58]

Interventions before age 7 result in the best outcomes and the earlier the better.

What should an optimal response in New Zealand look like?

This section presents recommendations for what to do next in New Zealand, based on conclusions from the local and international evidence.

Current services are approachable and have positive feedback from clients

Our survey of current service providers showed that they report good responses from clients in the form of positive feedback and engagement. We also found that they tend to deliver interventions focused on psychoeducation and advocacy, which are supported by the international evidence for being the most approachable and well-received by clients. However, the evidence for these types of interventions is not as strong as that for other types such as psychotherapy and parenting skills training.

However, there is room for improvement and the environment is ripe for change

The Vulnerable Children's Act was introduced in 2014 and the Ministry for Vulnerable Children – Oranga Tamariki has been established in 2017. The current political context of social investment includes a focus on what works based on evidence,[59] and on intervening early for maximal impact.[60] In particular, Oranga Tamariki has a focus on services that are informed by knowledge about the impact of trauma on children's functioning, and on access to specialist services when needed.[61]

There is an opportunity for better variation in response. Current services are aimed at addressing the impacts of direct physical abuse on children, and may also be delivered to children exposed to family violence. However, evidence shows that exposure to family violence is just as damaging in its own right and thus requires targeted interventions, ideally at an early stage. Children can be quite resilient to a single incident, but repeat exposures to family violence pose a cumulative risk to their development.[62] Preventing exposure to family violence is also necessary for interrupting intergenerational cycles of violence.[1]

We can most effectively address the effects of exposure to family violence by targeting services to those families that undergo repeat referrals but do not meet criteria for a single catastrophic event.

New investments should be directed at psychotherapy and parenting skills training

Addressing the effects of family violence requires active treatment, not just removal from the situation and waiting.[63] Therapeutic interventions have the strongest evidence base but are challenging to provide because of the level of funding and staff expertise required.[53]

Psychoeducation receives generally positive feedback from clients,[41] but the international evidence about its effectiveness suggests that for maximal effectiveness, it needs to be delivered in combination with psychotherapy and/or parenting skills training. In addition, there is some evidence that safety planning aspects of psychoeducation can increase children's perceptions that the violence will continue, which may actually exacerbate their worries rather than alleviate them.[41] Parenting skills and psychotherapy interventions delivered in a complementary fashion are more expensive to deliver but have stronger evidence of effectiveness.[41,47] They also function to strengthen the positive relationship between children and their non-abusive parent, which is critical to enabling children to heal from their experiences and support them in moving forward.[64]

Collectively, the international evidence is most promising for psychotherapy (particularly CBT) and parenting skills training, and thus new investments should be aimed here. The international evidence for advocacy and psychoeducation does not, according to the Evidence Rating Scale, currently support additional implementation in New Zealand beyond existing service provision, although it may hold more value if combined with other interventions such as psychotherapy[47] (and ratings can change as new evidence is produced and new interpretations of old evidence develop). This assessment is also endorsed by current service providers in New Zealand – when we asked them what gaps they saw in the current services provided for children exposed to family violence (results displayed in Figure 6), their most common response was difficulty accessing specialist or intensive services such as individual psychotherapy (30%). Currently, mainstream counselling services have long waiting lists and are thus difficult to access.[65]

Figure 6: Gaps seen by service providers in the current services provided for children exposed to family violence

Improved referral processes can also increase access to services. Currently, police conduct routine recording and referral whenever they attend a family violence incident where children are present. However screening for family violence should also occur routinely in doctors' clinics and hospitals, and during home visits from health professionals (eg Plunket nurses), as these may be the only place where some children come into contact with any services.[66–68] The ability to screen for family violence exposure in health settings can be limited by lack of time, practitioner worry about causing offence to patients (by asking about family violence), and reluctance to conduct screenings in the presence of children.[62] Addressing these barriers with workforce and community education, and adequate funding and resourcing are very effective at increasing screening rates.[30,62] Because direct and indirect exposures are equally harmful, practitioners should screen for a broad range of exposure types across a variety of contexts,[69] and do so consistently with accurate screening tools.[30]

Because direct and indirect exposures are equally harmful, practitioners should screen for a broad range of exposure types.

Better services can be delivered by attracting qualified staff and supporting up-skilling

Service providers also identified a lack of qualified staff as a key gap facing current responses for children exposed to family violence. International research shows that the high needs of families experiencing violence necessitates highly qualified staff in order to adequately address those needs.[68,70–72] When clients' needs exceed the capacity of service provider staff, funding becomes ineffective because the impact is so low.[70,71] Thus in order to have any real impact, adequate compensation is necessary in order to attract the qualified staff that will make the most difference for families.

Expert staff such as psychologists also have a greater capacity to provide trauma-informed interventions because they understand the influence of traumatic experiences on how people feel, react, make choices, and function.[73,74] Trauma-informed programmes have evidence for greater positive outcomes,[41,42] and children identify the components of such interventions as important parts of their recovery.[75] Because the impacts of exposure to violence can be so severe, addressing them requires highly trained and expert staff.

Evidence about New Zealand programmes needs to be built further

The evidence base about interventions for children exposed to family violence in New Zealand is lacking and needs to be built up. This requires funders to help service providers evaluate their programmes in order to generate evidence about what works in the New Zealand context.

In order to know how effective programmes are, providers need to have the resources and capacity to not only conduct an evaluation, but to be able to use and share the results in order to improve their and others' programmes. Responses to our survey indicate that the capacity to conduct and use robust evaluation evidence across the service delivery sector is varied but in need of support. For example, while many providers' programmes had been evaluated, fewer than one in three providers indicated that their programme was based on theoretical evidence, which is a necessary precondition for even Level 1 of Superu's Evidence Rating Scale. Other sources of evidence cited (eg continuing to get referrals, the fact that the programme is funded) also suggest that some providers may lack knowledge about what constitutes robust evidence of effectiveness for their programme. Superu is working to help build the quality of evidence across the social sector, including by providing tools to help service delivery organisations conduct evaluations and increase their capacity for understanding and generating evidence.

This includes building evidence for kaupapa Māori services. Interventions based on Western models are not necessarily directly applicable for Māori because they do not address the complex interplay of family violence with other factors such as colonisation, poverty, and social marginalisation.[54] Interventions for other indigenous peoples have some aspects in common with kaupapa Māori approaches (eg a holistic understanding of health and wellbeing) and may be useful. Interventions for Māori also need to stem from an understanding of whānau violence that recognises and addresses the complex interplay of factors which underlie family violence among Māori and influence the impact on children.[54]

Children's voices and needs should be prioritised

For services to be effective, it is important to focus on the child's needs – many traditional interventions tend to be adult- and victim-focused.[38,76] They also need to be tailored to different qualities, experiences and situations of children.[31,42,43,77] Women's refuges employ some child advocate workers but these positions are vulnerable to funding cuts.[65]

Children feel more comfortable reaching out to people who they already know,[38] which suggests community education might have the biggest reach. Often these people are likely to be teachers, family or friends, and so increasing the resources and knowledge of these groups is warranted. Evidence shows that the therapeutic relationship between service provider staff and children is crucial to the success of any intervention.[78] Group settings can also be helpful in addressing trust barriers for children.[79]

Children are aware of the tense atmosphere in the home, and believe that family violence is a secret, so they don't open up and have little knowledge of who can help them anyway.[80] Children say that being safe and talking with their family and friends are important, but they do not have similar trust with professionals and so this needs to be established first.[38]

Children want to be active in their family's safety planning as it gives them a sense of ownership and control over their recovery, and builds self-esteem.[81,82] They also appreciate being asked what they want to do, and having family violence talked about at school.[39]

The evidence base in New Zealand needs to be built up.

Support the supports – holistic care has a greater impact

Guiding principles for protecting children exposed to family violence[3] include the provision of holistic support and support for the non-abusive parent and their relationship with the children, as well as coordinated services with adequate resourcing.

The most lasting and valuable changes occur when services for non-offending parents and for children are integrated.[30,42,47,72] Providing services and support to non-abusive parents has flow-on benefits to children[83] because it helps establish an ongoing support system for them.[78,82] Current practices and referral processes rely on adults being able to protect children, and victimised parents having the capacity to stop the violence. Such responses ignore the barriers which prevent victims from stopping violence from others, can increase their risk of harm, and take onus away from the perpetrators of violence.[1] Instead, services should act to protect and support children exposed to family violence alongside their non-abusive parents and victims of the violence.

The services implemented in New Zealand also need to be linked, with good inter-agency collaboration[43,84,85] so that all services and agencies who come into contact with children exposed to family violence are working consistently together and no children 'slip through the cracks'.[67,74] Effective collaboration enables the varying needs of different children and families to be met with appropriate services.[30,47,72,82] Integrated services will better reflect the intertwined and co-occurring nature of different forms of family violence and enable interventions for children and non-abusive parents to address both of their needs.[7]

Schools are an advantageous setting for interventions (both universal and targeted)[86] because they are less limited by practical factors such as accessibility,[79] however schools often lack resources to deliver them.

The most lasting and valuable changes occur when services for non-offending parents and for children are integrated.

What can people who work directly with families do?

Current evidence shows that service providers in New Zealand are already delivering interventions that gather good feedback from clients, but what they can provide is also limited by their resources and capacity. While policy changes have potential to significantly improve our current response to children exposed to family violence, service provider staff who work directly with children can begin applying these findings. Our recommendations for good practice are:

1. Before anything else, make sure that the exposure to violence is stopped and that the child is safe. Addressing the impact of any exposure is going to be highly limited (although not unwarranted) when exposure to violence is ongoing.

2. Conduct routine and comprehensive screening and assessment so that you can understand the child. This will enable you to better tailor services to meet their needs. Use established screening tools – information about various tools can be found at **nctsn.org/resources/online-research/measures-review**

3. Think about which interventions are most appropriate for this child and their family, and as best you can, tailor what you offer for each child according to the needs identified. For example, children with more severe impacts might benefit most from referral to specialist services. Adolescent boys might do better in group than individual therapy. Where possible, offer complementary services for children and their non-abusive parents and work to strengthen their relationship with each other.

4. Build your organisation's capacity to generate evidence about your programme's effectiveness by learning how to conduct evaluations. Superu has developed tools for service delivery organisations which can help you. Find these tools at **thehub.superu.govt.nz/superu/evaluation-capacity-tools**

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Notes

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Superu is a government agency that focuses on what works to improve the lives of families, children and whānau.

What we do:

- We generate evidence that helps decision-makers understand complex social issues and what works to address them.
- We share evidence about what works with the people who make decisions on social services.
- We support decision-makers to use evidence to make better decisions to improve social outcomes.

We also provide independent assurance by:

- developing standards of evidence and good practice guidelines.
- supporting the use of evidence and good evaluation by others in the social sector.

Related Superu publications:

An evidence rating scale for New Zealand (March 2017)

Tools for organisations wanting to build their evaluation capacity (May 2017)

What Works: Integrated social services for vulnerable people (November 2015)

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