

Children affected by domestic and family violence

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

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Executive summary

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

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

The research had two areas of focus:

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

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

The research

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

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

prevention, early intervention and response programs and services focusing on children aged 0–8 years who are affected by DFV in NSW and other Australian states and territories.

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

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

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

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

Main findings and policy implications

The need for a coherent philosophy and integrated responses

This research has demonstrated that a range of approaches and understandings of primary prevention, early intervention and response for children aged 0–8 exist among stakeholders and in the literature. Theoretical distinctions are often not maintained in practice with a

wide overlap in the activities, services and programs undertaken, and ambiguity or uncertainty of the definitions of early intervention, primary prevention and response. In part this reflects the complexity of addressing DFV, and it also evidences a need for a clear framework to guide understanding and practice. A further issue that emerged strongly from the research, and has been highlighted in other analyses of DFV responses, is the extent to which services across different sectors work independently and in isolation from each other. **The research suggests a significant need for better integration of services for children, including better communication and integration between family violence services and other systems including the child protection system, the state-based justice system, family support systems such as those that deliver maternal and child health services, and the education system.**

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

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

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

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

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

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

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

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

In general, early intervention models were understood as models that targeted populations of children or pregnant women/new parents at higher risk of experiencing DFV. We

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

Responding to children exposed to DFV

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

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

The association between children's exposure to DFV and future perpetration of violence (the intergenerational transmission of violence) was much debated in the literature, mainly centring on whether the association is causal or the result of other interrelating factors such as maltreatment. Programs for children addressing the intergenerational transmission are recommended in the literature, though there is little evidence of their efficacy. Several of the therapeutic group programs identified in our service mapping aim to address this via psycho-educational activities. However, while the literature emphasised the importance of addressing the future perpetration by or victimisation of children exposed to DFV, our stakeholders and interview participants were more predominately concerned with children's immediate to medium-term post-crisis needs and the ability of services to adequately meet these needs. The best practice strategy most commonly raised in stakeholder responses to children exposed to DFV, was the importance for services to be child-centred, tailored to the child's individual need and family context, and to work holistically with the child's

mother/family, school and broader community. However, stakeholders identified that existing services were overburdened and unable to meet community demands for service. There was also some concern with allied health services, schools, and early childhood services being ill-equipped to respond to and identify children exposed to DFV. **There is broad need for more specialised children’s DFV services (therapeutic and post-crisis response) and sector capacity building in the education and health professions.**

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

Summary

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

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

1 Introduction and methodology

This research, carried out by the Australian Institute of Family Studies (AIFS) between July 2013 and June 2014, employed several different elements to assist in better understanding what works and what doesn't work in undertaking domestic and family violence (DFV) prevention, early intervention and response activities with young children. The study methodology consisted of a literature review and two main methods of collecting data from a range of professionals who work in and with the DFV sector in Australia.

This report **does not** focus on prevention and early intervention initiatives aimed at men. We acknowledge the need for holding perpetrators, not women and children, accountable for DFV, and the necessity of ongoing primary prevention of DFV addressing men. However, the key focus of this research project is on prevention and early intervention strategies for children and it is beyond the scope of this report to engage in a detailed discussion of perpetrator programs or primary prevention activities targeting men.

This study is one of three related projects commissioned by the NSW Department of Family and Community Services following a competitive tender process conducted in May 2013. The other related projects are concerned with:

- domestic and family violence prevention and early intervention initiatives focusing on women who are at higher risk of experiencing DFV or who face barriers in accessing DFV services (also conducted by AIFS); and
- domestic and family violence prevention programs focusing on men and boys (conducted by a research team led by Professor Moira Carmody from the University of Western Sydney).

This research program aims to assist in building a stronger evidence base on prevention and early intervention and to support the implementation of the *National Plan to Reduce Violence Against Women and Their Children 2010–2022 (National Plan)*. The research is also intended to inform funding decisions by the NSW Department of Family and Community Services by setting out recommendations for continued, enhanced or new approaches and exemplar models to support implementation in NSW of its new DFV framework, *It Stops Here*.

1.1 Background

The *National Plan*, endorsed by the Council of Australian Governments (COAG), represents an intention to coordinate action to prevent and respond to DFV over 12 years across state and territory governments and the Commonwealth. The National Plan is an important element in demonstrating Australia's commitments to upholding the human rights of Australian women through the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration to End Violence Against Women, and the Beijing Declaration and Platform for Action.

The *National Plan* is being implemented through four three-year plans, commencing with the National Implementation Plan for the First Action Plan 2010–2013 that was released in 2012. A further three action plans, each covering a three-year period, will be developed

sequentially to support the overall plan. At the time this report was being prepared, the second three-year action plan was being developed.

The First Action Plan includes four priorities that the various states and territories will work towards while also developing their own plans reflecting their specific priorities. The four overarching priorities are:

- Building primary prevention capacity;
- Enhancing service delivery;
- Strengthening justice responses;
- Building the evidence base.

Complementing and supporting the National Plan are the actions of various state and territory governments to seek to improve the way government and non-government organisations work together to prevent and respond to DFV. In NSW, this intention is reflected in the *It Stops Here: Standing Together to End Domestic and Family Violence* reforms, which propose a number of priority areas for action. These include:

- an integrated and coordinated state-wide system that has an increased focus on violence prevention;
- changes to victim service and support systems; and
- implementing programs and services that hold perpetrators accountable and reduce re-offending.

This study helps to address a gap in the existing evidence base by examining what primary prevention services currently exist for children aged 0–8 years who are affected by family violence, and by providing an evidence-based analysis of which approaches are most effective in addressing their needs. Drawing on the insights from this mixed method research project, this report offers insights into enhanced approaches to preventing and responding to young children affected by DFV. Together, the various aspects of the study inform a series of recommendations to underpin decisions made about future service delivery, criteria against which services for children can be assessed and methodological approaches for future evaluations.

1.2 Research methodology

As noted at the outset, the purpose of this study is to identify how children are impacted by DFV, what services children need, what is being done to support them, what models of service delivery are most effective, and what gaps may exist in services. Additionally, the research aims to identify current Australian prevention, early intervention and response programs for 0–8 year old children. A series of research questions examining issues pertinent to understanding the practice and organisational approaches of DFV prevention and early intervention services guided data collection for this study. These were:

- What role do current DFV services play in addressing the short and long-term needs of children?
- How are services doing this?
- What are the characteristics of good practices in child-centred DFV prevention, early intervention and support services?

- What strategies and programs should be supported to build on existing good practice and ensure that a child-centred response to DFV is implemented throughout NSW?

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

Key decisions on implementing aspects of the methodology were made in consultation with the NSW Department of Family and Community Services. The development of the methodology was informed by:

- the literature on effective prevention and early intervention to reduce violence against women and children; and
- reviews of existing evaluations about prevention initiatives.

The AIFS Human Research Ethics Committee provided the ethical review for this study. No incidents occurred that required reporting to the committee. Although the research questions did not seek to understand individual experiences of domestic and family violence, the nature of the research and the potential vulnerability of the populations who access or participate in the services and programs on which the research was focused generated some ethical issues that required consideration by the research team. This included the need to maintain confidentiality for professional respondents and report data in a way that ensured that individuals who provided information on a confidential basis could not be identified.

The necessity of addressing these issues is reflected in the research strategy in the following ways.

- The research team included researchers with a history of conducting research on a variety of sensitive topics, including DFV, and with participants from diverse backgrounds.
- In order to maintain confidentiality, care was taken to report research data in a way that does not identify individual informants. In some instances, findings have been presented in a way that reflects high-level conclusions without detailed discussion of the data. Particular care has been taken to ensure that the identity of professionals (who did not give permission to be identified) cannot be gleaned from this report. In accordance with ethics requirements, all interview and consultation transcripts were de-identified, and the original transcripts and recordings were destroyed.

The following sections set out the particular approaches taken for each aspect of the methodology, which were undertaken in stages over a 12-month period.

1.2.1 Literature review and identification of program examples

This aspect of the project involved three tasks: 1) a review of the research literature on the prevalence and impact of DFV on children aged 0–8 years; 2) an analysis of current evidence, conceptual frameworks and good practice trends related to prevention, early

intervention and response initiatives targeting children aged 0–8 years who are affected by DFV; and 3) a service mapping exercise to identify examples of prevention, early intervention and response initiatives focusing on children aged 0–8 years who are affected by DFV in NSW and other Australian states and territories.

Literature review

The literature review conducted by the research team was based on a rapid evidence assessment methodology to provide an overview of existing research focusing on the prevalence and impact of DFV on children aged 0–8 years, and characteristics of good practice in relation to DFV prevention, early intervention and response activities targeting young children (aged 0–8 years) who are affected by DFV. This approach was selected for this study in response to the timeframe set out in the project brief, and also allowed the research team to manage the breadth of the research process.

The research team searched a range of databases through EBSCOhost, which hosts academic, scientific and grey literature.¹ Additionally, the research team searched several Australian databases (e.g., Australian Family and Society Abstracts, APAIS (Australian Public Affairs Information Service), and CINCH (Australian Criminology database), and the AIFS Promising Practice Profile database. Also searched, were the AIFS library catalogue, the Australian Domestic and Family Violence Clearinghouse database, the New Zealand Family Violence Clearinghouse database, and websites of relevant peak bodies and organisations. The following international databases were included in the review: PsychInfo, and SocIndex. In addition, the research team utilised web-based search engines (e.g., Google) to capture other online resources that were included in the review. Relevant journals such as the *Journal of Family Violence*, the *Journal of Interpersonal Violence*, and *Journal of Aggression, Maltreatment and Trauma* were also manually searched in case any articles were missed in the broader searches.

The literature review strategy specified keywords, publication dates, and research methodologies to ensure the most relevant, reliable and up-to-date information was collected.

The research team searched literature concerning a range of topics: (a) the impact of DFV on children aged 0–8 years; (b) conceptual frameworks and debates on DFV prevention and early intervention approaches broadly, and specifically with children aged 0–8 years; (c) criteria and guidelines for good DFV practice; and (d) published evaluations of existing DFV prevention, early intervention and response programs or projects focusing on young children affected by DFV.

As relevant references were identified, the research team entered the details into a reference management program (EndNote). As the literature review progressed, members of the research team continually assessed the relevance of identified literature for inclusion in the database using a common set of criteria. These criteria were that the report or publication concerned any of the following:

- Literature that examined the impacts of DFV on children;

¹ Grey literature refers to published and unpublished reports, documents, evaluations that are not peer reviewed.

- Conceptual frameworks and debates on DFV prevention and early intervention;
- Particular studies or evaluations of DFV programs or services targeting children aged 0–8 years;
- DFV response practice with children, especially young children; or
- DFV practice criteria or guidelines more generally.

The literature search was supplemented by a hand-search of bibliographies and references for frequently cited references. This allowed the team to identify prominent researchers in the field and perform a further search of references by such authors to identify key ideas, concepts of relevance, and historical knowledge that may have been overlooked.

Identifying examples of prevention and early intervention initiatives focusing on children aged 0–8 years who are affected by DFV

In addition to reviewing the existing research focusing on the characteristics of good practice in relation to DFV prevention, early intervention and response activities targeting young children, the research team assembled a database of examples of initiatives focusing on children aged 0–8 years. Given the breadth of the research brief and the available resources, this database is not a comprehensive catalogue of all available services.

The research team utilised a number of methods to identify examples of relevant prevention, early intervention and response initiatives. The approach was largely based on a “snowball” strategy, including:

- identifying relevant services and programs from the reports and publications sourced as part of the literature review process;
- stakeholders and key informants providing information about various services and programs; and
- web-based searches.

Members of the research team assessed the relevance of services and programs for inclusion in the database using a common set of criteria. These criteria were that the information available about the service or program indicated the following:

- The program or service had a focus on DFV issues.
- The program or service focused on children, especially young children.
- The program or service undertook activities that could be classified as prevention, early intervention or response (broadly defined).
- The program or service was currently or recently operational.

Once an identified service or program was assessed as broadly relevant, the research team entered details about the program in the database of examples. The database is included for reference at Appendix 1.

Stakeholder consultations

Consultations were conducted with key stakeholders in three Australian states and territories. The consultations focused on identifying current characteristics of DFV practice and the key issues in undertaking prevention, early intervention and response activities in respect of children affected by DFV. Although the consultations were initially intended to

be conducted specifically in relation to the issues concerning services focusing on young children (with separate consultations taking place for the other related AIFS research project focusing on at-risk groups and communities), the research team found that the boundaries between service and program activities were blurred to the extent that separate consultations were not always appropriate or feasible. As a consequence, much of the stakeholder consultation activity was undertaken jointly with stakeholders who were also concerned with DFV prevention and early intervention programs focusing on women who were at higher risk of experiencing DFV, or who faced barriers in accessing DFV services. For this reason, the data reported from stakeholder consultations may be reflected in the findings presented in both AIFS reports.

The research team undertook stakeholder consultations in two stages. First, drawing on the information obtained through the literature review and existing relationships within the DFV sector, the research team identified relevant key stakeholders and organisations that either represented the interests of young children affected by DFV or had expertise in delivering DFV programs to meet their needs. Preliminary consultations were conducted with 27 identified key stakeholders, with the aim of 1) raising awareness about the research and securing their support, and 2) understanding the key issues in DFV prevention and early intervention from their particular practice perspective.

These preliminary consultations were conducted by telephone and predominantly took place in September and October 2013. Consultations were usually conducted with one researcher and one participant, however in some instances more than two participants were involved. These consultations ranged in length from 5–10 minutes to up to 60 minutes, depending on the participant. These preliminary consultations were not recorded or transcribed, but the researcher took notes of the key issues.

Following the preliminary consultations, the research team conducted a series of more formal stakeholder consultations in the form of five half-day roundtables. Roundtables were held in Sydney, Melbourne and Brisbane. Decisions about the locations for the roundtables were made in the context of project resourcing and were based on an assessment of where identified services and stakeholders were predominantly located.

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

The roundtables sessions were conducted in person using conference rooms located at the Australian Institute of Family Studies (Melbourne), the NSW Department of Family and Community Services (Sydney) and the Women's Legal Service (Brisbane). Participants for each roundtable were recruited using a "snowball" strategy, initially employing a variety of AIFS communication networks (e.g., AIFS website, AIFS events email alert, Australian Centre for the Study of Sexual Assault email alert, Communities for Children Australia email alert) and making direct contact with identified services and programs. These initial

contacts were then recruited to circulate information about the research, including invitations to attend the roundtable sessions, via email through their own practice networks. A list of services that participated in the roundtables is included at Appendix 2.

The roundtable sessions took place in November 2013. With the consent of the participants, the sessions were audio recorded and transcribed. In order to protect the identity of individual participants, the transcriptions were rendered anonymous and the original recordings destroyed.

In the original project brief, a third element of the consultation strategy was to have been conducted by participating in the Prevention Partnerships Advisory Committee, managed by the NSW Department of Family and Community Services. The planned committee did not go ahead and consequently the research team did not undertake this aspect of the original consultation plan.

Data from the stakeholder consultations were synthesised into responses to the research questions. Synthesised responses were further integrated into the report. The conclusions set out in the final chapter inform the implementation of enhanced or new approaches and exemplar models in NSW.

Request for information

Drawing on the data collected during the various stakeholder consultations and also the literature review, the research team developed and circulated a Request for Information to service providers and program operators. Using an online data collection instrument, the information request covered:

- the type of initiative or program;
- the nature of the host organisation through which the program or initiative is delivered;
- risk assessment or screening protocols;
- the theoretical underpinnings of the program;
- the range of services provided as part of the program;
- the structure and content of the program;
- client characteristics (including attendance and completion rates);
- whether any internal or external evaluation has been undertaken;
- whether any administrative program data exists that could contribute to an evaluation;
- and
- any other information identified as being relevant.

A copy of the Request for Information is included for reference at Appendix 3.

The Request for Information also gave service providers and program operators the opportunity to identify what they viewed as the characteristics and principles of good practice. The information request was initially promoted through AIFS' e-communication channels (e.g., ACSSA-alert; CFCA-alert) and our stakeholder networks. Participants were also recruited using a "snowball" strategy that relied on these initial contacts circulating information about the request to their own practice networks.

Sixty-nine service providers and program managers completed the Request for Information in full, and a further 35 service providers and program managers submitted usable partially completed responses. As was the case with the stakeholder consultations, service providers and program managers responding to the Request for Information often indicated that the service or program had a focus on both young children and also at-risk groups and communities. For this reason, the data reported from the Request for Information may be reflected in the findings presented in both AIFS reports.

1.3 Structure of this report

This introduction has discussed the rationale for and methodology of our research report focusing on children aged 0–8 years affected by DFV. The following chapter sets out the background and key issues on DFV prevention and early intervention by drawing on the findings of the literature review conducted for this study and considering the role of the core policy frameworks, namely the *National Plan* and *It Stops Here*. Chapter 3 examines the literature on the prevalence and impact of DFV on young children, while Chapter 4 outlines the theoretical debates relating to the causes of DFV and how these theories are linked to the key frameworks and policies for primary prevention. Chapter 5 provides an overview of the characteristics of effective prevention, early intervention and response approaches, while Chapter 6 offers some examples of current prevention, early intervention and response activities focusing on young children. Chapters 7 and 8 consider the key enablers and barriers in delivering domestic and family violence prevention and early intervention initiatives in respect of children affected by DFV. The final chapter brings together the main findings of the research and addresses the key research questions.

2 Background, definitions and policy contexts

This chapter addresses some important policy issues of relevance to the discussion in this report. It discusses definitions of DFV, influential contemporary policy frameworks and the concepts of primary prevention, early intervention and response in relation to DFV. Frameworks that are relevant nationally and in NSW are a particular focus of the discussion. This discussion establishes the backdrop to the specific discussion of children that follows in subsequent chapters.

2.1 Definitions

There is no single definition of DFV and varying terminology is used in policy, practice and research, including family violence, intimate partner violence, and domestic violence. The term domestic and family violence (DFV) is applied in this report because it is consistent with the terminology applied in NSW. In relation to the wider phenomenon of DFV, legislative policy and practice definitions vary but there is a significant amount of overlap between the definitions adopted in various areas. In recent years, there has been a move towards broader definitions of DFV that acknowledge a range of abusive behaviours wider than physical harm. Many contemporary definitions refer not only to physical abuse but also to a range of other behaviours including emotional abuse, sexual abuse, financial deprivation and social and cultural isolation. These definitions often refer to behaviours that are coercive and controlling, recognise that DVF is gendered in nature, and that children are often exposed directly or indirectly to family violence.

The Commonwealth Government's *National Plan to Reduce Violence against Women and their Children* (COAG, 2009) acknowledges that laws and polices in each state have their own definitions, and distinguishes between the terms "Domestic Violence" and "Family Violence":

Domestic Violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal, and non-criminal. Domestic violence includes physical, sexual, emotional and psychological abuse ... Family Violence is a broader term that refers to violence between family members, as well as violence between intimate partners ... the term "family violence" is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur. (COAG, 2009, p. 2)

"Domestic *and* family violence" is the term adopted in the most recent NSW policy framework *It Stops Here* (2014) which defines it as:

any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually

manifested as a part of a pattern of controlling or coercive behaviour. (NSW Government, 2014, p. 5)

This definition was developed in consultation with government and community organisations to reflect the diversity of women’s experiences and acknowledge “women in intimate partner relationships are the group in overwhelming need but that protection is essential for all victims” (NSW Government, 2014, p. 6). Further explanation refers to an inclusive definition of “intimate relationship” encompassing past and present circumstances and not limited to situations where there has been a sexual relationship (NSW Government, 2014, p. 7). “Family relationship” is explained as, “people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, siblings and extended family relationships”. It includes the full range of kinship ties in Aboriginal and Torres Strait Islander (ATSI) communities, extended family relationships, and constructs of family within lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) communities. People living in the same house, people living in the same residential care facility and people reliant on care may also be considered to be in a domestic relationship if their relationship exhibits dynamics which may foster coercive and abusive behaviours” (NSW Government, 2014, p.7).

Like some statutory definitions, the *It Stops Here* definition provides a non-exhaustive list of examples of the kinds of behaviour that may constitute DFV. They include:

- physical violence, including assault or abuse;
- sexual assault and other sexually abusive or coercive behaviour;
- emotional or psychological abuse including verbal abuse and threats of violence;
- economic abuse, for example denying a person reasonable financial autonomy or financial support;
- stalking, for example harassment, intimidation or coercion of the other person’s family in order to cause fear or ongoing harassment, including through the use of electronic communication of social media;
- kidnapping or deprivation of liberty, as well as unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture;
- damage to property, irrespective of whether the victim owns the property;
- causing injury or death to an animal, irrespective of whether the victim owns the animal.

The gendered nature of DFV is acknowledged and emphasised by both the *National Plan* and the NSW framework. For example, the *National Plan* states that while a small number of men experience this kind of violence, “the majority of people who experience this kind of violence are women—in a home, at the hands of men they know” (COAG, 2009, p. 1). *It Stops Here* states that: DFV is predominately, but not exclusively, perpetrated by men against women and children” (NSW Government, 2014, p. 6).

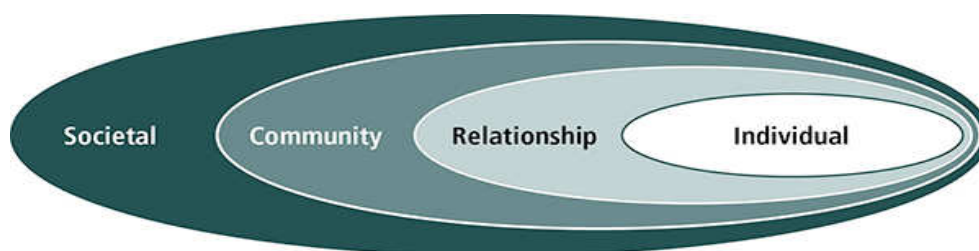
What is primary prevention?

Primary prevention of DFV is a key focus of international, national and state policy frameworks (NSW Government, 2013; VicHealth, 2007; Victorian Government, 2012; WHO, 2010). Primary prevention approaches address the underlying causes of DFV and aim to prevent violence before it occurs by “changing behaviours to prevent an undesirable social consequence” (Quadara & Wall, 2012, p. 3). Primary prevention is not (only) about increasing knowledge and awareness, but must also aim to influence attitudes that will bring about behavioural change. DFV and sexual assault primary prevention strategies target the risk factors or conditions that may give rise to gender-based violence, such as: gender inequality; gender socialisation; and social norms (Quadara & Wall, 2012; Walden, 2014).

2.2 A public health approach to DFV

In this section we provide a descriptive overview of current policies and frameworks that are influential in current approaches to DFV prevention, early intervention and response. As explained earlier, the *National Plan* establishes the national agenda and the NSW Government’s *It Stops Here* framework sets out the reform approach for that state. Each of these frameworks emphasises the importance of reducing the prevalence of DFV through primary prevention initiatives, in addition to recognising an ongoing need for early intervention and improved tertiary responses to DFV.

Since the 1990s, a public health model conceptualisation of DFV has been influential in the development of Australian policies (Murray & Powell, 2011; Walden, Barrett Meyering & Wall, 2014) and in frameworks such as those developed by the World Health Organisation (WHO) (2002, 2010) and VicHealth (2007). We discuss the theoretical background and debates in greater detail in chapter 3. At this point we briefly explain the public health approach taken by the main policy frameworks in Australia. A public health model approach acknowledges that DFV “is preventable and should therefore be the focus of sustained government and community effort” (Walden, 2014). A socio-ecological understanding of DFV as having “multiple causes” is a key feature of the public health model (Walden et al., 2014; WHO 2002; 2010). The socio-ecological conceptualisation of DFV, and more broadly gender-based violence and sexual assault, views it as the outcome of “multiple risk factors and causes, interacting at four levels of a nested hierarchy” (WHO, 2010, p. 7). These four levels are: individual; relationship/family; community; and wider society. This perspective recognises that each of these factors may have varying levels of influence, in particular social, economic, biological, cultural and political contexts, in the occurrence of family violence (WHO, 2010).



Source: Quadara & Wall, 2012, p. 4

Figure 1: Ecological model of the factors influencing sexual violence perpetration

2.2.1 *VicHealth: Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*

In 2004, the Victorian Government commissioned VicHealth to conduct a study into the economic cost of violence against women in Victoria. The report outlined the economic “burden of disease” caused by DFV finding that DFV was the leading cause of preventable death, disability, and illness for Victorian women aged between 15–24 (VicHealth, 2004, p. 10). Walden et al. (2014, p. 7) noted that this analysis reflected a “growing acknowledgement” internationally that gendered violence resulted in a heavy health-related burden that was prevalent but also preventable. This led to the development of the 2007 *Preventing Violence Before It Occurs: A Framework and Background Paper to Guide the Primary Prevention of Violence Against Women in Victoria* framework. This framework assumed a public health approach to DFV and argued that the prevalence of DFV is too high to only intervene *after* violence has occurred. It is based on the socio-ecological understanding of DFV proposed by WHO in 2002, and recognises that the underlying causes of DFV are a result of gendered relations of power. On the basis of research evidence, the VicHealth report recommended that action to prevent violence against women is best guided by three interrelated themes:

1. Promoting equal and respectful relationships between men and women.
2. Promoting non-violent social norms and reducing the effects of prior exposure to violence (especially on children).
3. Improving access to resources and systems of support.

2.2.2 *The World Health Organisation: Preventing intimate and sexual violence against women*

The WHO’s *Preventing Intimate Partner and Sexual Violence Against Women* framework (2010) drew on gender, human rights and criminal justice perspectives on prevention. It aimed to provide information for planners and policy-makers to develop evidence-based prevention programs. There is a strong emphasis throughout the document on the need to draw upon evidence of what is known about the causes of DFV when developing policies and implementing practices, as well as the need to generate evidence through rigorous evaluations (WHO, 2010). This report followed on from the an earlier *Global Report on Violence Against Women* (WHO, 2002) which located DFV and sexual assault in a continuum of interpersonal violence against women and framed it as a worldwide public health issue. The 2010 report was designed to review international evidence regarding the causes of violence against women and models of good practice in the area of prevention. A key point regarding evidence is that (at the time of publication), only one approach had been established as effective—school-based programs to prevent violence in dating relationships. However, the report also encourages the consideration of other contexts in which DFV prevention programs are run, as those most at risk of being a victim or perpetrator are often not engaged in formal education and so will not always access programs run in schools, universities and so on.

2.2.3 The National Plan

The National Council to Reduce Violence against Women and their Children was formed in May 2008, following a commitment by the Australian Labor Party during the 2007 election campaign. *Time for Action: The National Council's Plan for Australia to Reduce Violence Against Women and Their Children 2009–2021* was released, along with a Background Paper, in March 2009. This was followed by the *National Plan to Reduce Violence against Women and their Children 2010–2022* in February 2011. This Plan was endorsed by COAG and included a three-year action plan. The National Implementation Plan for the First Action Plan 2010–2013 was released in 2012. A further three action plans, each covering a three-year period, will be released to support the overall plan. Additionally, a national organisation was established, The Foundation to Prevent Violence Against Women and Their Children, to work towards raising awareness and engaging community in action to prevent DFV. Australia's National Research Organisation for Women's Safety (ANROWS) was also established as an initiative under the National Plan, aiming to drive and deliver research evidence and policy recommendations on preventing violence against women and children.

The *National Plan* is based on a public health, socio-ecological model for understanding violence, directly drawing on the *World Report on Violence and Health* (WHO, 2002) and the *Preventing Violence Before it Occurs* (VicHealth, 2007).

Key issues identified in *Time for Action* include:

- the fragmented nature of state, territory and national systems;
- significant barriers to collaboration and partnership, which impede the capacity to implement cross-departmental and inter-agency reforms and to monitor such reforms;
- gaps between policy intent and implementation. For example, policies and laws at times interact to the detriment of women and children's safety. There is inadequate portability of DFV orders across state borders and contradictory impacts of dealing with the family law, child protection and justice systems. There is variation in definitions regarding consent in sexual assault matters.
- failure to invest in primary prevention. Anti-DFV communications campaigns are not sustained and do not have a coherent message. Evidence indicates that positive campaigns focused on messages promoting cultural and behavioural change, rather than focused on victims and encouraging them to access services, are most effective, yet this is not reflected in the funding of primary prevention campaigns.
- inadequate funding of services. This has impacts on the workforce—it is difficult to attract and retain skilled staff to work in a complex and underpaid area.
- responses that are not tailored and accessible. Current services do not meet the diverse needs of women and children. Services (such as housing, employment, children's health, education, etc.) are not integrated to address the multiple impacts of violence.
- the lack of evidence about what stops men's violence against women. Instead, focus is on the criminal justice system and sentencing.
- the inadequate monitoring and reporting. Data and evaluation evidence is consistently lacking. It is necessary to set a baseline for monitoring change over time, which is agreed to by all levels of government.

The *National Plan* focuses on six high-level outcomes:

- Communities are safe and free from violence.
- Relationships are respectful.
- Indigenous communities are strengthened.
- Services meet the needs of the women and their children experiencing violence.
- Justice responses are effective.
- Perpetrators stop their violence and are held to account.

The First Action Plan (2010–2013) included four priorities that the various states and territories were to work towards while also developing their own plans that reflect their specific priorities. The four overarching priorities are:

- building primary prevention capacity;
- enhancing service delivery;
- strengthening justice responses;
- building the evidence base.

2.2.4 NSW: *It Stops Here*

The NSW framework *It Stops Here: Standing Together to End Domestic Violence in NSW* focuses on the reforms that have been developed in response to systemic problems identified in the DFV service sector in NSW. It draws on the NSW Auditor General’s report *Responding to Domestic and Family Violence* (2011) and wide consultations with the DFV sector which “made it clear” that reforms were needed in the way NSW was responding to DFV. Problems identified included:

- victims facing obstacles in gaining support and protection, specifically:
 - barriers to speaking up and identifying themselves as victims of DFV;
 - difficulty negotiating pathways within and between services to get the help they need.

The reforms focused on in the report included:

- changes that enable better identification and support of people who face a threat to their safety;
- increased cohesion and integration between workers from government and non-government agencies to better respond to people needing support;
- better information sharing, enabling people to move between agencies without having to re-tell their story.

There is also a strong emphasis on using evidence to inform targeted primary prevention work in the NSW community. The framework aims to deliver five broad outcomes (2014, p. 12):

- DFV is prevented.
- DFV is identified early.
- Victims are safe and supported to recover.
- Perpetrators stop using violence.
- A supported, professional and effective sector is developed.

The framework recognises that underlying causes of DFV are complex but that “to a large extent they reflect deeply held views in society about gender, masculinity, power and relationships” (2014, p. 14). Thus it recommends that prevention should focus on challenging “disrespectful, discriminatory attitudes and beliefs that allow violence to occur” (2014, p. 14).

2.3 Policies and frameworks relating specifically to children

Children’s exposure to DFV has become a prominent policy issue comparatively recently (Humphreys, 2014; Richards, 2011). In the past two decades, mounting empirical evidence about the extent to which children are exposed to DFV and the impact this has on their development has created impetus for policy responses to this issue (Bromfield, Lamont, Parker, & Horsfell, 2010; Goddard & Bedi, 2010; Humphries, 2014; Humphries & Houghton, 2008; Powell & Murray, 2008; Richards, 2011). Such responses are reflected in the recognition of exposure to family violence as a form of child abuse in state and territory child protection frameworks, the Commonwealth Government’s *Protecting Children is Everyone’s Business: The National Framework for Protecting Australia’s Children 2009-2020 (National Framework)* (COAG, 2009), and the federal *Family Law Act 1975* (Cth).

Recent evidence indicates that where DFV occurs between adults in families with children, children are more likely than not to be exposed (Australian Bureau of Statistics [ABS], 2014; CFCA, 2013b; De Maio, Kaspiw, Smart, Dunstan, & Moore, 2013). The nature of children’s exposure to DVF is manifold, ranging from witnessing (including seeing and overhearing violence and witnessing its impact) to being directly caught up. As Murray and Powell (2008) explained, children were previously seen as “silent witnesses” to DFV, however a now substantial body of research indicates children may be involved in and impacted by DFV in a range of ways. These include being used as physical weapons; being forced to watch or participate in assaults; being forced to spy on a parent; being blamed for the violence; and intervening to stop the violence occurring (Buckley & Holt, 2007; Carroll-Lind, Chapman, & Raskauskas, 2011; Edleson, 1999; Edleson, Mbilinyi, Beeman, & Hagemester, 2003; Indermaur, 2001; Mullender, Hague, Imam, Kelly, Malos, & Regan, 2002; Stanley, Miller, & Richardson Foster, 2012).

In relation to the impact of exposure to DFV, empirical studies in the past 20 years have established the negative psychosocial and developmental outcomes for children exposed to DFV (Bedi & Goddard, 2007; Bogat, Levendosky, von Eye, & Davidson, 2011; Holt, Buckley & Whelan, 2008; Richards, 2011). A further influence on policy approaches to children’s exposure to DVF derive from Australia’s obligations as a signatory to the *United Nations Convention on the Rights of the Child* [UNCRC](Article 19) (1989) which recognises that children have a universal right to live free from all forms of violence. In 2011, the United Nations Committee on the Rights of the Child released an expanded comment regarding Article 19, which re-emphasised the obligation of signatory states to ensure this right including, among other forms of violence, the right to be free of violence in the home. The committee states that this obligation includes that nations act to prohibit, prevent and respond to violence against children through “legislative, judicial, social and educational measures” (2011, p. 6).

In part, a rationale for the *National Framework* is Australia's obligations as a signatory to the UNCRC. It establishes a national approach to child protection, which, due to the division of legislative power under Australia's Constitution falls within the responsibility of the states and territories. The *National Framework* is based on a public health, preventative approach to child protection. The high level goals of the *National Framework* are to ensure that:

- children live in safe and supportive families and communities;
- children and families access adequate support to promote safety and intervene early;
- risk factors for child abuse and neglect are addressed;
- children who have been abused or neglected receive the support and care they need for their safety and wellbeing;
- Indigenous children are supported and safe in their families and communities; and
- child sexual abuse and exploitation are prevented and survivors receive adequate support.

The *National Framework* emphasises the need to move away from seeing “protecting children” as a response to abuse and neglect. Rather, it focuses on the promotion of the safety and wellbeing of children and is based on a wider conception of child wellbeing than that embodied in child protection systems. Given that child protection systems receive many notifications and make far fewer substantiations, the *National Framework* is premised on the notion that the kinds of support children need go beyond the responses offered by the child protection system.

The NSW Government has its own framework for protecting children: *Keep Them Safe: A Shared Approach to Child Wellbeing (2009)*. The *Keep Them Safe* framework is a five-year plan to reshape NSW's response to child safety and includes actions to improve prevention and early intervention services, and better protect children at risk through the integration of government and non-government organisations in the delivery of services. The measures that are part of this strategy are the subject of an extensive evaluation program and have not been the focus of this research.

2.3.1 *Intersection of child protection, family law and DFV policies*

The complexity of the relationship between the different policy responses of family law, child protection and DFV, and their respective impact on children, has been widely examined in the literature. Hester (2011) referred to the fraught relationship between these sectors as the “three planet model” with their own histories, philosophies, laws, and sets of professionals making responses to DFV where children are involved, difficult, contradictory and, at times, unsafe.

DFV and allegations of child abuse and/or neglect in the context of the breakdown of parental relationships in Australia may intersect two separate legal systems. This is because the state/territory-based child protection system is responsible for investigating child safety concerns and these concerns are issues that are also relevant to the resolution of post-separation parenting arrangements in the federal family law system. Significant issues have been identified in relation to the interaction of these legal systems in terms of achieving

effective and timely outcomes in the best interests of children (Australian Law Reform Commission [ALRC] and NSW Law Reform Commission [NSWLRC], 2010; Chisolm, 2009; Family Law Courts [FLC], 2009; Higgins & Kaspiew, 2011). While the Family Court of Australia's Magellan case management system has, to a significant degree, ameliorated difficulties arising from the lack of coordination between these overlapping frameworks for family law cases involving serious allegations of child abuse (Higgins, 2007), a comprehensive approach that deals with the 'jurisdictional (and consequently philosophical and administrative) gaps' (Higgins & Kaspiew, 2008, p. 236) between the child protection system and the family law system remains outstanding. This absence of a comprehensive approach is particularly pertinent given the prevalence of concerns about child abuse and neglect in family law cases (Kaspiew et al., 2009).

Similarly, the relationship between DFV policies and child protection policies at the state government level has been fraught with difficulties. The recognition that DFV is a form of harm to children has led to policy and legislative responses to women and children that are potentially problematic (Buckley, Whelan, & Carr, 2010; Cross, Mathews, Scott, & Gourmet, 2012; Humphreys, 2008; Humphreys, 2014; Laing, 2003; Powell & Murray, 2008). Mandatory reporting of DFV where children are present is enshrined in law in New South Wales, Tasmania and the Northern Territory (CFCA, 2013a). This has led to increases in reporting to child protection authorities, which has overburdened the system without necessarily improving child safety (Humphreys, 2007; Jacob & Fanning, 2006). Studies in the United States and Australia suggest that an unintended consequence of mandatory reporting, is that women living with DFV are less likely to call the police because of the fear of mandated child protection referral, particularly in Indigenous communities given the history of child removal (Cross et al., 2012; Humphreys, 2008). Humphreys (2008) identifies a philosophical/theoretical tension arising out of the different historical trajectories of DFV services and child protection (see also Hester, 2011). While DFV service arose from the feminist movement of the 1970s and 1980s, child protection has a more "ambiguous and coercive" history linked to the forcible removal of children (Humphreys, 2008, p. 233). Furthermore, there are problems in the way child protection responds whereby it can hold women responsible for children's safety and not the perpetrator. Thus "failure to protect" is an accusation levelled at women rather than focusing on the perpetrator.

2.3.2 Integrated systems: current thinking and practice

The integration of responses to DFV from government and non-government agencies is increasingly understood as critical in addressing such a complex problem. The development of integrated responses has occurred in response to concerns about the effectiveness of service provision for service users and the perceived need to address differences in philosophical and organisational responses to the issue (Ross, Frere, Healey, & Humphreys, 2011). At the base of integrated approaches is the understanding that a complex, seemingly intractable issue such as DFV requires a coordinated response (Healey & Humphreys, 2013). There is an assumption that sector coordination improves outcomes for victims, reduces secondary victimisation and can assist in addressing gaps in the service sector (Healey & Humphreys, 2013).

There are various understandings of what an integrated system means, as well as questions about how coordinated or integrated a system needs to be to be most effective (Healey & Humphreys, 2013; Marcus, 2011). Most commentators agree that systems tend to sit somewhere on a continuum from collaboration at the local, service delivery level to coordination between agencies in at least some of their processes to integration, which usually involves a strategic, jurisdiction-wide approach with multiple tiers of management.

Marcus (2011) identifies some of the key features of integrated models as including:

- an identified lead agency (i.e. a government department);
- shared vision, values, principles;
- common goals/action plan;
- common protocols and responses;
- cross-agency training;
- clear internal actions for each agency;
- enhanced evidence gathering/protective strategies;
- information sharing and agreements and protocols;
- common risk assessment protocols and tools; and
- multi-agency case management reviews.

Healey and Humphreys (2013; see also Murphy, Paton, Gulliver & Fanslow, 2013) stress the importance of governance structures. They argued that a clear governance system must be implemented in some form in order for integration to survive in the long term (Healey & Humphreys, 2013). This does not need to be a strictly hierarchical arrangement but must involve coordination and monitoring (Healey & Humphreys, 2013).

Most integrated systems involve “horizontal” integration (aligning the actions and goals of various service areas) and “vertical” integration (coordinating the actions and priorities of services, agencies and government departments up and down the lines of accountability) (Ross et al., 2011).

Coordinated and integrated responses to DFV are evident in all jurisdictions in Australia, although where they sit on the spectrum of integration is variable (Healey & Humphreys, 2013). Healey and Humphreys (2013) provide a good overview of the arrangements in each Australian jurisdiction. As discussed above, integration and collaboration of services where children are involved have been challenging due to the differing philosophies, professional discourses, and cultures from which various services involved are professionally located (e.g., child protection, family law, DFV services) (Hester, 2011; Murphy, et al., 2013).

2.4 Prevention, early intervention and response: blurred boundaries

Broadly, it is understood that:

- primary prevention approaches address the underlying causes of DFV and aim to prevent violence before it occurs. Primary prevention strategies may be delivered universally to whole populations, or directed at people at a higher risk of experiencing DFV (Walden, 2014).

- secondary prevention, or early intervention, focuses on those at risk of perpetration or victimisation. The VicHealth framework uses the term “early intervention strategies” (2007). And
- tertiary prevention addresses the longer-term needs that follow on from the experience of violence, including, for example, rehabilitation and strategies to reduce trauma (WHO, 2010). The VicHealth framework uses the term “intervention strategies” (2007).

There are several aspects of this schema that raise complexities that are relevant to the presentation of findings in this report. These complexities are also acknowledged in the literature on prevention approaches in DFV (and sexual assault) (Quadara & Wall, 2012; VicHealth, 2007; Whitaker, Murphy, Eckhardt, Hodges, Cowart, 2013). Fundamentally, they relate to the way that theoretical distinctions at each level of prevention may not be reflected in practice, with some programs operating at two or more levels. These distinctions are pertinent to several dimensions of prevention (Quadara & Wall, 2012). The first dimension relates to the timing of the intervention, reflected in the terms “primary”, “secondary” and “tertiary”, implying that the strategies address prevention at different time points: in practice some programs operate across these time points.

The second dimension is the population group targeted by the strategy (Quadara & Wall, 2012). This dimension has a number of significant aspects, and one fundamental aspect is whether the strategy is aimed at preventing perpetration or victimisation. Again, some prevention strategies, particularly those that operate at the population level and are intended to support attitudinal change, address the prevention of perpetration and victimisation. Other strategies may be targeted at preventing either perpetration or victimisation. But in some contexts, such as measures to prevent the transmission of inter-generational violence, the distinction between the status of victim and perpetrator is ambiguous, since measures targeted at (helping) victims (children exposed to DFV) are (also) intended to prevent them from becoming perpetrators or being re-victimised (Jaffe, Wolfe, & Campbell, 2012).

The third overarching dimension concerns the way the prevention strategy operates in the wider socio-ecological context (Quadara & Wall, 2012). In this regard, the basis of the strategy, and how it is formulated to address DFV in its particular context, require consideration. Relevant issues in this area necessitate attention being paid to the characteristics of the target population, the factors that contribute to that population becoming DVF perpetrators or victims and how the strategy addresses each of these issues, as well as the extent to which it is intended to operate as a primary, secondary or tertiary strategy (see e.g., Whitaker et al., 2013). In relation to primary prevention work with children, it has been argued that dividing primary and secondary prevention is not always useful as significant numbers of children are already involved in violent relationships or exposed to DFV in the home. Children may have already formed views on violence and gender by the time they reach secondary school; consequently, activities categorised as primary prevention come, in fact, after the event for some children (Ellis, 2008).

These theoretical insights have informed the way that the data collection and analysis strategies in this research have been applied. In light of the particular focus of this report, the following discussion sets out insights from the literature that are of relevance to children.

2.5 Summary and policy implications

This chapter has considered the policy context for this report, including the development of the *National Framework*, the *National Plan* and the NSW-based *It Stops Here* strategy. The definition of DFV applied in this report is consistent with the broad and inclusive definition set out in *It Stops Here*, recognising the diversity of women and children's experiences and acknowledging the gendered nature of DFV. Additionally, this chapter has outlined the key international and national frameworks for the primary prevention of DFV, which espouse a public health socio-ecological approach. The socio-ecological approach is premised on an understanding that DFV has multiple causes at varying levels of influence, but that gender inequality is key to understanding the pervasiveness of DFV. As such, policy frameworks both nationally and internationally emphasise that prevention activities should aim to challenge traditional gender stereotypes and create cultures of non-tolerance towards DFV. This chapter also acknowledged the sometimes fraught and contradictory relationships between the different policy frameworks and judicial contexts relevant to children; namely child protection, DFV services, and family law. The importance of collaborative and integrated approaches to DFV responses and prevention was raised, and it is noted that collaborative, integrated approaches are particularly pertinent to responses to children given these differing policy contexts.

We also raised the complexity of the concept of primary prevention in a practice setting, with practice approaches often positioning themselves as operating at this level, in addition to the secondary and tertiary levels. The need for DVF prevention strategies aimed at children in the 0–8 age group is based on the recognition of the need to implement primary prevention strategies early, before behaviours and attitudes become fixed. A further issue reinforcing the need of a focus on 0–8 year olds is the research evidence about the extent to which they are exposed to DFV and the adverse impacts such exposure has. This is discussed in some depth in the next chapter.

3 The prevalence and impact of DFV on children

In this chapter we examine the statistical evidence of the extent to which children are exposed to DFV, the implications of such exposure and some of the main theoretical and empirical understandings of childhood exposure to DFV. There is a considerable amount of evidence showing that children experience a range of negative impacts over the short and longer term from such exposure; however, understanding of how this occurs and what factors mitigate against sustained adverse outcomes is only now emerging.

3.1 Prevalence

Until recently, it has been difficult to ascertain the extent to which children are exposed to DFV. As Richards (2011) pointed out, there are a number of reasons for this, including a dominant focus on the main victim; underreporting of DFV in general; and parents underestimating the extent of their children's exposure to DFV. Recently, quantitative research has established the extent to which Australian children have experienced DFV, particularly within separated families. The Australian Bureau of Statistics' (2013) *Personal Safety Survey* found that 17% of Australian women over the age of 18 had experienced partner violence since the age of 15 (n = 1,479,900 women).² Of those women, 54% had children in their care at the time of the violence and 22% of children had heard the violence and 31% of them had seen the violence.

Four community-based studies reviewed by Child Family Community Australia (CFCA, 2013b) estimated prevalence of children witnessing DFV at between 4–23%. AIFS *Longitudinal Study of Separated Families* (Kaspiew et al., 2009) found that of the 10,002 separated parents surveyed, 16.8% of fathers and 26% of mothers reported experiencing physical hurt at the hands of their former partner.³ Of the parents who reported experiencing physical violence before separation, 72% of mothers and 63% of fathers reported that their children had witnessed the violence (Kaspiew et al., 2009). Similarly, the Institute's *Survey of Recently Separated Parents* (De Maio et al., 2013) found that the experience of family violence was common among separating families. Of the 6119 parents surveyed, 68% of mothers and 58% of fathers reported emotional abuse, and 24% of mothers and 16% of fathers reported physical violence. Of the parents who reported emotional or physical violence prior to separating, 53% of fathers and 64% of mothers reported that their children had either seen or heard the violence or abuse (De Maio et al., 2013).

Analysis from the Victorian Victims of Crime Family Violence Database reveals that between 2009–10 children were present in 24,180 police incident responses to DFV (Victims Support Agency, 2011). The Australian component of the *International Violence Against Women Survey* (Mouzos & Makkai, 2004) found that of the women who had

² The ABS defined violence as “any incident involving the occurrence, attempt or threat of either physical or sexual assault experienced by a person since the age of 15” (ABS, 2013).

³ Kaspiew et al. (2009) defined DFV as either physical or emotional abuse.

experienced DFV, 36% reported their children witnessing the violence. The available data therefore suggests that significant numbers of Australian children experience DFV.

Within Indigenous populations, prevalence of child exposure is far more frequent, with higher rates of DFV within Aboriginal and Torres Strait Islander populations when compared to non-Aboriginal and Torres Strait Islander people (HREOC, 2006; Millward, 2013)

Research over the last 20 years has unequivocally determined that children exposed to violence in the home suffer a wide range of poor psychosocial and health outcomes (Bedi & Goddard, 2007; Heugten & Wilson, 2008; Holt et al., 2008; Howell, 2011; Jaffe et al., 2012; Klitzman, Gaylord, Holt, & Kenny, 2003; Margolin & Vickerman, 2011; Spilsbury et al., 2008). The literature indicates that exposure to DFV in childhood is associated with depression, anxiety, trauma symptoms, aggression, lower social competence, low self-esteem, fear and loneliness. Children exposed to DFV in childhood may also have poorer academic outcomes, higher rates of peer conflict and impaired cognitive functioning (Klitzman et al., 2003; Tuyen & Larsen, 2012). Health and socio-economic impacts include higher likelihood of future alcohol and drug abuse, depression, unemployment and homelessness (Ellonen, Piispa, Peltonen, & Oranen, 2013; Yates, 2013). However, there are considerable divergences in outcomes and impacts in different populations of children (Holt et al., 2008) and resilience in children is not well understood.

The findings from a diverse body of literature are referred to in the following discussion. It provides an overview of insights from studies that have sought to determine the various psychosocial and long-term health and development outcomes in children via longitudinal research, meta-analyses and experiential studies, as well as findings from studies that have examined children's experiences more directly via qualitative interviews and surveys. The first part of the discussion raises some methodological complexities that arise in assessing impact. Then, studies that focus on impacts in some distinct areas—trauma and attachment and cognitive functioning—are discussed. Research insights into factors that support resilience despite exposure to DFV are then considered. The section concludes with a discussion of research based on children's accounts of exposure to DFV.

3.2 The “constellation of risk”

Several authors suggest that studies assessing the impact of children's exposure to violence may be fraught with methodological problems and urge caution in drawing cause and effect assumptions regarding children's exposure (Chan & Yeung, 2009; DeBoard-Lucas & Grych, 2011; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Heugten & Wilson, 2008). One identified difficulty concerns the samples on which some research is based. Some studies, for example, have been based on unique populations of children drawn from refuges or shelters, thus representing the most recently and “severely affected” population (Gewirtz & Edelson, 2007, p. 798). Additionally, the literature suggests that children's exposure to DFV occurs within what DeBoard-Lucas and Grych (2011) call, a “constellation of risk” and disadvantage. That is, DFV often occurs alongside a host of other risk factors such as parental substance abuse, poverty, family dysfunction, other forms of child abuse and neglect, mental ill-health, and social isolation (Bromfield et al.,

2010; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Higgins, 2004; Moylan, Herrenkohl, Sousa, Tajima, Herrenkohl, Russo, 2010).

Gewirtz and Edleson (2007) propose, therefore, that developmental difficulties and poor outcomes in children exposed to DFV might reflect a convergence of risk factors. It is consequently difficult to separate the effects of these factors from the effects of exposure to DFV. As Holt et al. (2008, p. 803) highlight, “the presence of multiple stressors in a child’s life may both elevate the risk of negative outcomes and possibly render indistinct the exact relationship between domestic violence and those negative outcomes”.

There is particular focus in the literature on the interrelatedness of DFV and other forms of child maltreatment (Bromfield et al., 2010; Gewirtz & Edleson, 2007; Goddard & Bedi, 2010; Guille, 2004; Herrenkohl, Sousa, Tajima, Herrenkohl & Moylan, 2008; Higgins, 2004; Holt et al., 2008; Price-Robertson, Higgins, & Vassallo, 2013) and growing recognition that outcomes of experiencing different types of maltreatment are thus hard to differentiate (Higgins, 2004; Price-Robertson et al., 2013).

Herrenkohl et al.’s (2008) widely cited systematic literature review examined the intersection of child abuse and DFV. The review of over 500 studies found a “considerable overlap” between DFV and other forms of child maltreatment. Herrenkohl et al. concluded that child abuse compounds the impact of DFV and increases the likelihood of psychosocial problems in youth and adulthood. Drawing on data collected from three Australian studies of childhood relationships, family functioning and adult adjustment, Higgins (2004) suggested that distinction between the impacts of different types of child maltreatment are unclear as children have often experienced more than one type of maltreatment. Moylan et al. (2009) used data from a longitudinal study examining the long-term effects of child maltreatment and found that dual exposure to DFV and child abuse increased children’s risk of externalising and internalising behaviours in late adolescence.

Holt et al.’s (2008) literature review also suggested that DFV and other child maltreatment often go hand-in-hand. They point out, though, that convergence rates vary according to the study sample and location, with abuse more likely to occur in highly disadvantaged populations (see also Bromfield et al., 2010).

3.3 Trauma and attachment theory

A central concern in the literature on the impact of childhood exposure to DFV focuses on the combined effect of trauma from exposure to DFV and the related implications for the attachment relationships of children so exposed (Bedi & Goddard, 2007; Howell, 2011; Jaffe et al., 2012; Margolin & Vickerman, 2011). The main concerns in this context are twofold. First, it is recognised that children may experience ongoing social, cognitive and emotional detriment through exposure to DFV. Second is that the attachment relationship between children and their primary caregivers, mainly mothers, may be impaired in families where DFV occurs, through the compromised ability of women subjected to DFV to protect their children and through their potentially impaired caregiving capacity due to their own experience of DFV. Concerns for child development in emotional, social and cognitive domains arise from the negative consequences of these interlocking issues. However, it is also recognised (Bedi & Goddard, 2007; Holt et al., 2008) that these concerns should not be used as a justification for stigmatising or penalising mothers who

experience DFV since accountability lies with the perpetrators. A further point is that these concerns may not necessarily be pertinent in all cases, as discussed further below.

In connection with trauma that may ensue from exposure to DFV, there are two relevant concepts. The narrower of these is the diagnostic term post-traumatic stress disorder (PTSD), which is “a common anxiety disorder that develops after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened”.⁴ Both mothers and children may experience PTSD from exposure to DFV, putting particular strains on each of these individuals and their relationships. The broader concept of complex trauma is also relevant. It is not an officially recognized diagnostic term but is rather a construct that describes “a broad-ranging set of disorders, symptoms and social problems that are not captured by the more limited PTSD category” (Wall & Quadara, 2014, p. 4). A range of symptoms may be evident in those suffering complex trauma, including dysfunction in affect regulation, alternations in attention or consciousness and alterations in self-perception (Wall & Quadara, 2014). Complex trauma is associated with sustained exposure to abusive interpersonal relationships in childhood (but this is not an exclusive context). A connection between impaired attachment relationships and the impact of such exposure is also central to the concept of complex trauma and its manifestations (Wall & Quadara, 2014).

The trauma and attachment theory suggests that children exposed to DFV may experience symptoms of PTSD resulting in psychosocial and sometimes physical responses that if left untreated, can have long-lasting developmental effects (Jaffe et al., 2012). Children can develop disorganised attachments (insecure attachment, anxious-avoidant, or anxious-resistant) to their primary caregivers when the ability of these caregivers to emotionally shield the child from the experience of trauma is compromised due to their own trauma, depression and stress (Gewirtz & Edelson, 2007; Margolin & Vickerman, 2011). Since secure attachment relationships support healthy child development, and are considered to be the foundation of healthy adult functioning, the long-term impact of insecure attachment relationships is viewed with considerable concern.

Margolin and Vickerman (2011) examined the literature about PTSD and children’s exposure to DFV, finding that PTSD has particular qualities when it occurs in relation to childhood experience of DFV. They argue that exposure to DFV has cumulative effects and that exposure to multiple traumas over time might result in complex disturbances such as an inability to regulate emotion, and cognitive and behavioural developmental delays. Margolin and Vickerman further suggest that children’s capacity to cope with trauma is compromised by the non-offending parent’s inability to act as a “buffer” to the trauma in the context of their own stress, trauma and depression (Margolin & Vickerman, 2011).

Holt et al.’s (2008) literature review examined studies published from 1995–2006. They found that DFV impacts on parental capacity, which, in turn, negatively affects children’s psychopathological outcomes. Holt et al. (2008) cite several studies that indicate maternal stress, depression and their own symptoms of trauma may result in emotionally indifferent and unavailable parenting.

⁴ <www.medicinenet.com/posttraumatic_stress_disorder/article.htm>

Howell (2011) reviewed the association between PTSD and children's exposure to violence with a particular focus on children of pre-school age. Howell suggested exposure to DFV for children in this age group raises some particular concerns because of their developmental stage and the fact that they may spend a greater proportion of time with their parents compared to school-age children and are thus not able to benefit from the buffering effects of exposure to a school environment. Her analysis shows that PTSD symptoms are evident in pre-school age children exposed to DFV and can result in both physical and psychological symptoms. Where infants and children cannot rely on parents or caregivers to protect from or buffer traumatic events, children may instead rely on self-protective behaviours such as withdrawal, anger and aggression (Howell, 2011). She argued that children suffering PTSD symptoms may have difficulty with developmental tasks due to poor emotion regulation and may have difficulty recognising emotions in others.

Gewirtz and Edelson's (2007) review of the literature, similarly found that "insecure attachment" as a result of compromised parenting capacity is associated with poor developmental outcomes and behavioural issues into adulthood. Jaffe et al.'s (2012) review of the literature additionally argued that children's exposure to trauma as a result of DFV might also have negative impacts on children's coping skills and self-esteem.

Holt et al. (2008) and Bedi and Goddard (2007), however, cautioned against holding mothers/non-offending parents responsible for children's exposure to DFV. They point to several studies suggesting non-offending parents sometimes go to great lengths to protect children from trauma. For example, a qualitative study of 54 children and 24 mothers who had experienced DFV in the United Kingdom (Mullender, 2002; Mullender et al., 2002) indicated that while mothers' relationships with their children were "deeply affected" (Mullender, 2002, p. 158), over half the mothers in the study felt they had made significant efforts and utilised various strategies to shelter their children from the violence that was occurring in the home. However, Mullender also found that despite these efforts, many mothers felt they could not fully protect their children from emotional or physical harm as offenders sometimes "deliberately used" children to hurt and control them (Mullender, 2002, p. 156). Holt et al. (2008) suggest that "failure to protect" is an accusation often levelled at the non-offending parent (2008, p. 801), diverting attention away from the offender. Guille's (2004) review of the literature, for instance, indicated that there was a lack of attention in the research given to the father-child relationship in the context of DFV.

3.4 Cognitive outcomes and future exposure to risk

Some studies suggest that exposure to DFV in childhood can affect children's cognitive functioning and is associated with poor academic outcomes and problems with schooling (Klitzman et al., 2003; Lundy & Grossman, 2005; Yates, 2013). Klitzman et al.'s (2003) meta-analysis of 118 empirical studies published between 1978 and 2000, found that 67% of children exposed to DFV are at risk of a range of developmental and adjustment problems and fare worse than average children in terms of academic success, cognitive ability, mental health and wellbeing. Similarly, Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe's (2003) meta-analysis of 41 empirical studies concluded that children's exposure to DFV is associated with a range of cognitive and behavioural problems and poorer academic outcomes.

Lundy and Grossman (2005) analysed data collected from a state-wide domestic violence service in the United States. They examined the data on 40,436 children relating to children's behaviour, physical and mental health, and schooling, as reported by mothers on service intake forms during 1990–95. Over half the children were reported as having significant behavioural problems and just over one-fifth had difficulties at school including poor class behaviour, learning difficulties, low school attendance and poor academic performance.

Schnurr and Lohman (2013) undertook a longitudinal analysis of data from a sample of 2000 children from a larger child welfare study in three US cities. Children were recruited to the study as toddlers, and then interviewed and assessed according to a variety of psychological and developmental measures four years later, when aged between 8 and 10 years. Schnurr and Lohman found a correlation between early exposure to DFV and behavioural and academic problems and low engagement with school during middle childhood. However, there was little impact on cognitive ability or physical health (Schnurr & Lohman, 2013). In qualitative studies assessing children's experiences, children and young adults describe significant impacts on their schooling as a result of living with DFV, including poor academic performance, bullying and high absenteeism (Tuyen & Larsen, 2012; Yates, 2013).

Exposure to DFV in childhood may also predict children's later involvement in risk activities such as abuse of alcohol or drugs, smoking, risky sexual behaviour, and future violence perpetration or victimisation (Ellonen et al., 2013; Heugten & Wilson, 2008). For example, a recent study by Ellonen et al. (2013) used data from a sample of 13,549 adolescents (aged 12–16) from the *Finnish Child Safety Survey* and found a higher association between childhood exposure to DFV and rates of substance abuse and “delinquency”.

There is some debate on the question of whether exposure to DFV is a factor in future perpetration of violence. Some reviews of the literature argue there is significant correlation between DFV in childhood and future perpetration in males (Gewirtz & Edleson, 2007; Holt et al., 2008; Jaffe et al., 2012). However, other authors suggest that evidence supportive of direct causation is inconclusive (Ali & Naylor, 2013; Ellis, Stanley & Bell, 2006; Fergusson, Boden & Horwood, 2006; Shorey, Cornelius & Bell, 2008; Temple, Shorey, Tortolero, Wolfe, Stuart, 2013). A key argument in the literature is that not all children who experience DFV go on to become perpetrators or victims and, likewise, not all perpetrators have a history of childhood violence or abuse: the social and family context in which DFV occurs is important for understanding these outcomes (Casey, Beadnell & Lindhorst, 2009; Ellis, 2004; Tomison, 2000). Fergusson et al.'s (2006) longitudinal analysis of a cohort of 10,000 young adults in New Zealand found that the association between adult perpetration of violence and child exposure to DFV was “weak”. Fergusson et al. suggested that the correlation could be explained instead by the “confounding psychosocial” context in which the DFV took place (2006, p. 103). The study found that DFV was more common among participants whose childhoods were “characterised by a number of adversities”, such as parental mental ill health, unemployment, poverty, family dysfunction, sexual abuse and “impaired parental bonding” (Fergusson et al., 2006, p. 103). In a smaller sample involving 36 male perpetrators, Bevan and Higgins (2002) found a unique correlation between childhood exposure to DFV and psychological abuse of spouses. However, closer analysis of inter-correlations of variables suggested that “rather

than physical abuse or witnessing family violence ... other forms of child maltreatment ... are important risk factors for the perpetration of domestic violence in adulthood” (Bevan & Higgins, 2002, p. 239). Bevan and Higgins (2002) found that childhood neglect, in particular, had a strong association with future physical perpetration of DFV. Higgins (2004, p. 54) suggested that child maltreatment types, including exposure to DFV, “should not be considered in isolation due the large degree of overlap between each form of abuse and neglect”. As such, Higgins argued that policies and practices should address the varying degree to which individuals have experienced different types of maltreatment (2004, p. 54).

3.5 Gender differences in outcomes

Most studies do not find significant differences in outcomes according to children’s gender; both boys and girls experience negative outcomes. There was some evidence to suggest girls showed more internalising behaviour (e.g. depression) while boys externalised behaviour (e.g. aggression) (Graham-Berman & Hughes, 2003). However, two meta-analyses that looked specifically at gender differences in children exposed to DFV found effects were similar for boys and girls (Klitzmann et al., 2003; Wolfe et al., 2003). One study found that boys exposed to DFV held more stereotyped beliefs about gender and were more accepting of violence than girls were (Graham-Berman & Brescoll, 2000). Theoretically, social learning theory holds that girls and boys will be impacted differently through modelling behaviour on the parent with whom they identify. As such, it is thought that boys learn that violence is acceptable while girls may learn to become victims (Jaffe et al., 2012). However, social learning theory is not well evidenced in the research literature and there are mediating factors that influence a child’s developmental outcome and future risk, as discussed above. We also discuss social learning theory and the intergenerational transmission of violence in the following chapter on causation.

3.6 Children's experiences

There is a small body of qualitative research examining children’s views and experiences of DFV (Bagshaw et al., 2010; Buckley & Holt, 2007; Carroll-Lind et al., 2011; Mudaly & Goddard, 2006; Mullender et al., 2002; Stanley, 2011; Stanley et al., 2012; Tuyen & Larsen, 2012; Yates, 2013). Buckley and Holt (2007) undertook in-depth interviews with 22 children who had experienced DFV in Ireland. Children described living with fear, anxiety and dread, and worried about the safety of their siblings, mothers and themselves. Children further conveyed feelings of shame about their home life, and thus lacked confidence and self-esteem, resulting in poor peer relationships. Moreover, some children described direct involvement in the violence; acting as mediators, or attempting to protect younger siblings and their mothers.

The widely cited Mullender et al. (2002) study was based on qualitative interviews with 54 children and 24 mothers who had experienced DFV in the United Kingdom. The children in this study described being present in a full range of DFV incidents, including attempted murder, emotional and, sometimes, sexual abuse. Like the Buckley et al. (2007) study, children described living with constant fear and anxiety and reported feelings of powerlessness and anger. They also described physical symptoms such as insomnia, headaches, and stomach upsets. Children used a variety of coping strategies to deal with the

violence including “blocking it out” by retreating into “private worlds”, leaving the house (if old enough), hiding, distraction through television or noisy play, talking to friends or relatives, and by attempting to mediate the violence.

In a national violence survey of 2077 New Zealand children aged between 9–13 years (Carroll- Lind et al., 2011), children were asked what kinds of violence they had been exposed to: 27% had witnessed emotional or physical violence between their parents and this was reported as having more of an impact on them than peer, community violence or media violence. Children in this study reported feeling powerless about parental violence, and feeling shame or stigma, which acted as a barrier for seeking help.

Tuyen and Larsen (2012) conducted a cross-sectional survey of 150 children in the United States, drawn from churches, youth groups, schools and sporting organisations. 32% of children in the study had witnessed parental violence and these children were more likely to indicate symptoms of depression. Children who had experienced DFV also reported anger, anxiety and insomnia. Older children and adolescents in the study reported taking on roles of responsibility in the family and felt they had to act to protect siblings and mothers from violence. Some expressed resentment at having to take on these roles, particularly as it had the effect of isolating them from their peers. Moreover, many described major disruptions to their schooling including poor concentration, being victims of bullying, absenteeism and poor academic performance.

3.7 Resilience in children

Several authors note that while the existing research on outcomes of exposure to DFV have been important, future research should examine what factors lead to resilience in children (De-Board-Lucas & Grych, 2011; Heugten & Wilson, 2008; Humphries & Houghton, 2008). Humphries and Houghton (2008) suggested that there is a danger of “over-pathologising” children who have experienced DFV, as the research indicates some children draw on a number of coping strategies and show resilience, while others do not exhibit any negative outcomes at all. For example, in Klitzman et al.’s (2003) meta-analysis, described above, 37% of children fair better or “no worse than the average child”.

The literature suggests that there are several factors that may mitigate children’s exposure to violence including the extent of children’s peer and social support; their relationship with mother or other primary caregiver; whether the violence was ongoing or short-term; age of child when the DFV occurred; and, whether children received an adequate response/treatment following the DFV (Gewirtz & Edeslon, 2007; Heugten & Wilson, 2008; Holt et al., 2008; Howell, 2011; Humphreys & Houghton, 2008; Martinez-Torteya, Bogat, Levendosky, 2009; Richards, 2011). Howell (2011) found that age was a significant factor in children’s resilience: older children fare better than younger children, probably because they are able to engage in activities outside the home and develop supportive relationships with peers or other relatives.

In qualitative studies, children report that strong relationships with peers, engagement in school activities, and being able to “escape” the family home were important coping strategies (Heugten & Wilson, 2008; Mullender et al., 2002; O’Brien, Cohen, Pooley, & Taylor, 2013; Thompson & Trice-Black, 2012; Willis et al., 2010; Yates, 2013). For younger children, Howell (2011) found that the most significant factor in resilience was a strong

parent/child attachment and therefore recommends that responses to children experiencing DFV should focus on strengthening the relationship between mother and child.

3.8 Summary and policy implications

This chapter has examined the evidence of the extent to which children are exposed to DFV, the implications of such exposure and the theoretical and empirical understandings of these implications. Statistics show that Australian children are exposed to DFV to a significant extent, particularly in separating families. There is a considerable amount of evidence to show that children experience negative impacts over the short and longer term from such exposure; however, understanding of how this occurs and what factors militate against sustained adverse outcomes is developing. There is a range of theories with varying levels of empirical support explaining the reasons for adverse outcomes. These include theories (the constellation of risk) that emphasise against drawing conclusions on the basis of any one perspective and highlight that given the widespread co-occurrence of DFV with other forms of child maltreatment, impacts of exposure to DFV are difficult to differentiate or determine. Some approaches are based on theories of trauma and attachment, while other evidence focuses more generally on identifying the cognitive sequelae of DFV exposure and risks that may follow later in life.

All of these perspectives contribute to the development of a better understanding of the impact of DFV on children, as does emerging research examining resilience. **This evidence reinforces the need for a multi-dimensional approach to both understanding the impacts and responding effectively to children aged 0–8 years. The co-occurrence of DFV alongside other forms of child maltreatment needs particular attention in policy and practice. Responses to children experiencing DFV should thus consider that children may be multi-victimised. Resilience in children seems linked to strong relationships with the non-offending caregiver and with access to treatment following exposure.**

4 Causes and prevention

The broad aim of this chapter is to describe current theoretical thinking and the rationale behind DFV primary prevention approaches. As described in Chapter 2, primary prevention of DFV is a key aim of national and state policies and is supported in international frameworks such as the WHO (2002; 2010). Approaches and strategies to prevent DFV are premised within various theories and assume various models of causation. There is widespread acknowledgement in policy frameworks that primary prevention of DFV should address the underlying causes contributing to violence, yet evidence regarding both the causes of DFV, and the effectiveness of various prevention strategies, is limited and very few prevention programs have been adequately evaluated (Flood, 2013; Whitaker et al., 2013; WHO, 2010).

4.1 Feminist conceptualisations

Feminist responses to DFV developed from the women's health and women's refuge movements of the 1970s and 1980s. In Australia, feminist organisations and campaigners have been influential in ensuring violence against women and children became a policy issue (Murray & Powell, 2011). In their overview of DFV policy in Australia, Murray and Powell argued that early government prevention efforts were largely based in a crime prevention or law and order approach, which placed emphasis on victims and "less commonly focused on attempts to change the behaviour of offenders themselves" (Murray & Powell, 2011, p. 144). However, the feminist perspective on violence resulted in a "conceptual shift" (2011, p. 38) in terms of policy that saw DFV move from being an individual problem to a structural/societal problem. Though there is no one feminist theory of DFV perpetration, it is broadly understood as an effect of patriarchal social structures and gender roles placing men in positions of power over women (Bell & Naugle, 2008; Murray & Powell, 2011; Woodin & O'Leary, 2009). Feminist explanations locate DFV in the social context of unequal power relationships; men's violence is understood as both an outcome and a response to gendered inequality. As such, it is argued that greater gender equality would reduce men's violence against women (Whaley, Messner, & Veysey, 2013). A gendered perspective on DFV recognises that:

domestic violence is one form of violence amongst others, including sexual assault and sexual harassment, that are experienced primarily by women, and that are ... almost exclusively perpetrated by men. (Murray & Powell, 2011, p. 38)

The feminist perspective has, however, been critiqued for its failure to account for the ways in which ethnicity, sexuality and race intersect with gender to produce different experiences (Bell & Naugle, 2008; Murray & Powell 2011). It has also been argued that it fails to adequately account for DFV in same-sex couples (Ball & Hayes, 2009). Most recently, the socio-ecological model encompasses a feminist approach but also emphasises individual, community and societal factors relevant to the prevalence of DFV.

4.2 The socio-ecological model

As briefly described in chapter 2, a public health, socio-ecological approach to primary prevention has been adopted in international and Australian policy (VicHealth, 2007; COAG, 2009; NSW Government, 2014; Victorian Government, 2012). The WHO has produced several key reports promoting a socio-ecological, public health model of primary prevention of DFV (Dahlberg & Krug, 2002; WHO, 2002; WHO, 2010), which are widely cited and influential in local policy frameworks. First theorised by Dutton (1985) and further developed by Heise (1998) the socio-ecological theory of DFV acknowledges that there is no single factor to explain DFV. Rather, violence is determined by a complex interplay of multiple and interrelated factors at four levels of influence: individual, family, community and society (Casey & Lindhorst, 2009; Dahlberg & Krug, 2002; Dutton, 1985; Heise, 1998; Quadara & Wall, 2012; WHO, 2010).

A gendered understanding of DFV is central to this model. Gender inequality, traditional gender roles and patriarchal social structures are understood to be at the core of violence against women, and these issues interact with other risk factors, such as exposure to violence in childhood, substance abuse and socio-economic status. A socio-ecological model encourages primary prevention of DFV in various contexts and on multiple levels of influence (Carmody et al., 2009; Flood & Pease, 2008; Heise, 1998; VicHealth, 2007; WHO, 2010). It prioritises a shifting of societal attitudes and norms regarding gender in order to create a “climate of non-tolerance” of DFV (WHO, 2010, p. 35; Murray & Powell, 2011).

The literature indicates the need for primary prevention strategies to be focused on attitudinal change, be informed by local community context, and be offered across the lifespan, including during childhood, in order to be effective (Casey & Lindhorst, 2009; Michau, 2007; Chan, Lam & Cheng, 2009). Thus, it is argued that primary prevention should occur in schools, local communities, peer groups, sporting and leisure organisations and workplaces (Ellis et al., 2006; Flood & Fergus, 2008; HREOC, 2006; Hughes & Fielding, 2006; VicHealth, 2007; Walden et al., 2014). Broader societal-based preventions targeting the national population, such as large-scale media/social media campaigns, have also been identified as necessary in addressing and altering attitudes and societal norms (Campbell & Manganello, 2006; Murray & Powell, 2011; VicHealth, 2007; WHO, 2010). WHO acknowledges that “dismantling the hierarchical constructions of masculinity and femininity” and eliminating inequality are long-term, challenging goals (2010, p. 36), and recognises that these broader macro-strategies should be complemented by “measures with more immediate effects” and informed by an evidence base.

Evidence base for a socio-ecological model

There is general recognition that the evidence basis for many primary prevention strategies remains emergent (Chalk, 2000; Cornelius & Resseguie, 2007; Flood, 2013; Murray & Graybeal, 2007; Whitaker et al., 2013; WHO, 2010). Chalk (2000), for example, argued that prevention and early intervention programs lack a rigorous evidence base, largely because they are difficult to evaluate due to heterogeneity and complexity of target populations, and are often based on “perceptions of individual need” rather than epidemiological data

Murray and Graybeal's (2007) systematic review of North American primary prevention program evaluations found a gap between research and practice. They argued that prevention is difficult to measure since outcomes are based on subtle attitudinal changes towards gender roles, violence and power in relationships. Moreover, very few program evaluations or studies are randomised—that is, they lack a comparable control group (Chalk, 2000; Murray & Graybeal, 2007; WHO, 2010). Whitaker et al. (2013) also asserted that the paucity of longitudinal studies on primary prevention initiatives means that long-term outcomes of programs or strategies are uncertain. However, Flood noted that while many have argued that the “gold standard” of evaluation is the randomised controlled trial, this type of study is inappropriate for many primary prevention projects, which are largely conducted by not-for-profit community organisations who “typically do not have the capacity to conduct evaluations based on an experimental design” and/or that have features which are not compatible with experimental study design/randomised controlled trials (2013, p. 13). Kwok (2013) reasoned that we should instead, focus on shorter-term gains/outcomes of prevention work, since shifting the root causes of DFV is a long-term endeavour requiring sustained effort over time, the results of which are unlikely to be seen in our lifetime.

Since evidence of what works in primary prevention is scarce, the rationale for a public health, socio-ecological approach to DFV prevention is largely “theory driven” (Kwok, 2013, p. 9) and based on what is known about factors associated with perpetration, particularly the correlation of violence against women with community attitudinal factors (Casey & Lindhorst, 2009; Flood & Pease, 2008; Heise, 1998; Kwok, 2013; Murray & Powell, 2011; VicHealth, 2007; WHO, 2010). Cross-sectional international studies and systematic reviews of the literature indicate that perpetration of violence against women is associated with attitudes supportive of traditional gender roles, gender inequality, beliefs about male entitlement, and acceptance of violence as a form of conflict resolution (Flood & Pease, 2008; Fulu, Jewkes, Roselli, & Garcia-Moreno, 2013; Hagemann-White, Kavemann, Kindler, Meysen, & Puchert, 2010; Jewkes, 2002; VicHealth, 2007; WHO, 2010). However, studies that have sought perpetrator childhood history and other social determinants, have found alcohol abuse, childhood trauma and/or childhood abuse and depression have also been associated with perpetration (Fulu et al., 2013; Hagemann-White et al., 2010).

4.3 Factors associated with perpetration

A recent systematic review of evidence in the “factors at play in perpetration” of violence and sexual violence against women and children concluded that, overall, the available evidence in this area is “unsatisfactory” (Hagemann-White et al., 2010). Hagemann-White et al. reviewed 130 studies in scientific journals and a further 90 peer reviewed, research-based publications using a rating system that prioritised meta-analyses, cross-cultural comparisons, and longitudinal studies. The authors were able to extract some conclusions about various factors associated with perpetration of violence against women. They identified four levels of influence in perpetration: ontogenetic, which includes individual life history factors such as family exposure to violence; micro, which includes peer, community, workplace or school influence; meso-societal, which refers to larger institutions such as government and church as well as norms, sanctions, etc.; and macro,

which refers to the “overall cultural, historical and economic structures of society” (Hagemann-White et al., 2010, p.6).

On the macro level, Hagemann-White et al. found that devaluation and subordination of women, normative beliefs about gender roles and the unequal distribution of power contributed to acceptance of violence against women (2010). Strong adherence to “normative heterosexual masculinity” (2010, p. 12) was also associated in some studies with perpetration. Cross-cultural studies, for example, suggest that societies that idealise masculinity have higher levels of violence. On the meso-societal level of influence, Hagemann-White et al. found that a failure of agencies/governments to implement sanctions on violence against women was associated with higher levels of violence. Other meso-societal factors linked (causally) to violence included poverty and disadvantage, gender discrimination in workplaces, “honour” codes and “hate groups”. Hagemann-White et al. found a “strong bias” in the research literature toward ontogenetic (causations) of perpetration. Hagemann-White et al. (2010) identified several factors associated with perpetration; these include history of poor parenting, maltreatment or abuse, early trauma, emotional disturbances/personality /cognitive disorders, and drug and alcohol abuse.

Fulu et al. (2012) conducted a multi-country, cross-sectional study on men and violence in Asia and the Pacific. A total of 10,178 men aged between 18–49 years were interviewed via household surveys in seven countries, which included questions regarding DFV and sexual assault perpetration, gender attitudes, and potential multivariate associated with perpetration of DFV such as poverty, low education, exposure to childhood trauma and alcohol abuse. Results suggested a correlation between perpetration of physical partner violence and:

- low education;
- experiences of trauma and abuse in childhood (particularly witnessing DFV);
- alcohol abuse;
- engagement in the purchasing of sex (specifically associated with perpetration of sexual abuse/rape);
- controlling behaviour by men towards their intimate partners;
- “gender-inequitable attitudes” (2012, p. 204).

Traditional attitudes towards gender roles have also been associated with higher tolerance for violence against women (Berkel, Vandiver & Bahner, 2004; Goode, Heppner, Hillenbrand-Gunn, & Wang, 1995; Simbandumwe, Bailey et al., 2008). For example, a qualitative study with immigrant men in Canada (Simbandumwe et al., 2008) found that some men felt the threat to their role as male breadwinner and identity as head of the family to be a justification for violence.

Attitudinal surveys of young people in Scotland, the USA and Australia suggest that violence-supportive attitudes are present among some peer groups, (Burman & Cartmel, 2005; Casey & Lindhorst, 2009; Indermaur, 2001; Rosewater, 2003; Young, 2004) and a VicHealth (2009) survey found that a significant minority of Australian men believed violence against women could be excused in certain circumstances. Several reviews of the literature (Casey et al., 2009; Flood & Pease, 2008; Heise, 1998; WHO, 2010) suggest that incidences of family violence are found to occur more frequently in communities where

there are low sanctions for violence, or in communities where there is a view that violence against women is sometimes justified, for instance in cases of infidelity.

Childhood exposure to DFV and future perpetration

As discussed in the previous chapter, there is some contention within the literature regarding the association between childhood exposure to DFV and future perpetration (Ali & Naylor, 2013; Bevan & Higgins, 2002; Ellis et al., 2006; Shorey et al., 2008; Temple et al., 2013; Tomison, 2000). Social learning theory posits that DFV is intergenerational, learned in childhood through behavioural modelling and observations of parents and peer relationships (Bell & Naugle, 2008; Ellis et al., 2006; Shorey et al., 2008; Woodin & O’Leary, 2009). In this model, it is hypothesised that “coercive and aversive interpersonal behaviours are learned through violent interaction in one’s family of origin” (Shorey et al., 2008), and it is understood that children learn that violence is an acceptable method of dealing with conflict (Jaffe et al., 2012). According to Jaffe et al. (2012) gender role modelling is an important aspect of this theory, as it is thought that children model behaviour on the parent they identify with: thus boys may become violent and girls may learn to become victims. In the social learning model, it is thought that prevention and early intervention should thus focus on developing skills and knowledge that will enable children to learn different ways of dealing with conflict, and in “unlearning” problem or undesirable behaviours (Ellis et al., 2006).

A further and related theory is the intergenerational transmission of violence theory, which sees perpetration in males as resulting from the trauma of witnessing or being victim to violence as a child (Bevan & Higgins, 2002; Kim, 2011). However, there is also some debate surrounding this theory. The argument put forth in the literature is that not all children who experience DFV go on to become perpetrators or victims and, likewise, not all perpetrators have a history of childhood violence or abuse. As discussed in the previous chapter, the social and family context in which the DFV occurs, and the co-occurrence of DFV exposure with other types of child maltreatment, are important for understanding these outcomes (Bevan & Higgins, 2002; Casey et al., 2009; Stith et al., 2000).

Social learning theory or the intergenerational transmission of violence theory, as a *comprehensive* explanation for DVF causation is thus viewed with some caution. Conversely, Whitaker et al. (2013) acknowledge that while the correlation is weak, exposure to DFV in childhood nonetheless needs to be addressed, as it appears often enough as a factor associated with perpetration. Whitaker et al. (2013) believe that exposure to DFV should be viewed alongside an array of risk factors in childhood that need to be addressed via specific prevention strategies.

4.4 Summary and policy implications

This chapter has outlined the most prominent theories of causation and prevention of DFV. Feminist theories have been widely influential in understanding DFV as directly linked to gendered relations of power. In the socio-ecological model, gender remains central, though there is acknowledgement that DFV is the result of a complex interplay of factors, at varying levels of influence. The socio-ecological approach to primary prevention thus aims to address the underlying cause of DFV by focusing on attitudinal change in

various contexts and across the lifespan. There is general agreement in the literature that since there is a paucity of evidence for “what works”, the socio-ecological model of primary prevention is largely theory-driven. That is, prevention strategies are based on what is known about perpetration. The literature around factors associated with perpetration strongly point to DFV as being linked with traditional/normative beliefs about gender, poor community sanctions for gendered violence, idealised masculinity, attitudes supportive of violence, low education, substance abuse and, less conclusively, with a childhood history of multiple forms of child abuse/maltreatment. The association between childhood exposure to DFV and future perpetration or victimisation was much debated in the literature, however.

The rationale for the need for a universal socio-ecological approach to prevention work lies in targeting/addressing multiple levels of risk.

In regard to children, the rationale for primary prevention is premised firstly on the theory that attitudes to gender and violence are formed in early childhood, and secondly, that children exposed to DFV or trauma *may* be at an increased risk of victimisation and/or perpetration (VicHealth 2007; Flood & Pease, 2008; Carmody, 2009; WHO 2010). A key focus within the WHO and VicHealth frameworks has thus been on primary prevention education targeted at young people and children, as their attitudes are more readily influenced than those of adults (Carmody, 2009). In the following chapter we go on to examine the broader literature supportive of primary prevention in early childhood.

5 Characteristics of effective approaches with children: insights from the literature

In this chapter we examine the literature on the efficacy of prevention and early intervention and response strategies with children. There is general consensus in the literature that there is a lack of evidence for what works with children. However, methodological reviews, meta-analyses and reviews of literature indicate that there is a greater evidence base for the efficacy of prevention strategies with children and young people that are delivered through schools (Chalk, 2000; Flood & Fergus, 2008; Hester & Westmarland, 2005; Murray & Graybeal, 2007; Whitaker et al., 2006; Whitaker et al., 2013). As such, WHO (2010) and VicHealth (2007) recommended school-based primary prevention with children and young people, and school-based primary prevention is also supported in the *National Plan* and *It Stops Here*. The nationwide, Respectful Relationships in Australian Schools program is funded through the *National Plan*. We examine the evidence and debates around school-based primary prevention, before considering the literature on early intervention and response.

5.1 Primary prevention and early intervention in school settings

5.1.1 Primary prevention in schools

There are several recommendations developed for best practice frameworks in the delivery of school-based primary prevention of DFV and sexual assault (Carmody et al., 2009; Fergus, 2006; Flood, Fergus & Heenan, 2009; Walsh & Peters, 2011). School-based primary prevention should:

- encompass a “whole of school approach”;⁵
- focus on attitudinal and behaviour change;
- be informed by a clear theoretical framework or “program logic” that acknowledges the underlying causes of DFV and sexual assault;
- be culturally inclusive and age appropriate;
- focus on gender equality and promote respectful relationships;
- work in conjunction with community services; and
- include an evaluation component.

The literature examining the value and efficacy of school-based programs for adolescents and young people is now extensive and there are several international and Australian evaluations and studies of such programs (Antle, Sullivan, Dryden, Karam, & Barbec, 2011; Ellis, 2004; Fergus, 2006; Flood et al., 2009; Flood & Kendrick, 2012; Foshee et al., 2004; Fox, Corr, Gadd, & Sim, 2014; Jaycox et al., 2006; Ollis, 2011; Tharp, 2012; Thiara & Ellis,

⁵ A whole of school approach operates across the curriculum and encompasses school policies and practices, school culture and ethos and the school community. It involves curriculum integration and reinforcement of prevention through school “policies, processes and structures”. (Flood et al., 2009, p. 89; Fergus, 2006).

2005; Tutty et al., 2005). Much of this literature, however, focuses on programs offered for secondary school students. Moreover, many programs for children and young people lack a gendered understanding or framework of DFV and sexual assault, and are based in social learning theory (Carmody, 2009; Ellis, 2004).

There is some debate within the literature regarding whether school-based DFV prevention programs should be theoretically informed by and specifically focused on gender and inequality (Capaldi & Langhinrichsen-Rohling, 2012; Ellis, 2008; Fox et al., 2014). Carmody (2009) argued that how gender is conceptualised and “how it impacts on program design varies significantly” in practice (2009, p. 7). Ellis’ (2004) review of primary prevention programs in primary and secondary schools in the United Kingdom suggested that gender was often neutralised and there was reluctance within some school populations to introducing a gender-based understanding of violence among primary school-aged children (see also Ellis, 2008). An evaluation of *Breaking the Silence* (Dyson, Barrett & Platt, 2011), a sector capacity building program which undertook professional development for teachers and principals in order to promote a whole of school “culture of respect”, also found that some participants in the training program were resistant to introducing concepts of gender-based violence and gender inequality to younger school children. Similarly, Ollis’ (2011) evaluation of a Respectful Relationship pilot program in several Melbourne secondary schools found that a number of teachers expressed concern with regard to framing violence in a gendered way as it had the potential to “alienate” boys.

There is consensus in the policy frameworks and wider literature, however, that primary prevention programs need to address the underlying causes of DFV—gender inequality—and be focused on bringing about attitudinal and cultural change (Carmody, 2009; Carmody et al., 2009; Quadara & Wall, 2012; Stathopoulos, 2013; VicHealth, 2007). As Carmody (2004) argued, the tendency in some primary prevention programs to neutralise gender contradicts the international evidence indicating the gendered nature of DFV and sexual assault and undermines the efficacy of such programs. Furthermore, there is a strong argument for primary prevention to begin in pre and primary school levels given that attitudes towards gender and violence may already be ingrained by the time children reach secondary school age (Ellis, 2008; Flood & Fergus, 2008).

Australian-based primary prevention programs for *secondary* school students are now numerous and many have been evaluated. For example, the Respect, Protect, Connect program (Fergus, 2006), LoveBites program (Flood & Kendrick, 2012), the Health, Respect, Life program, (SHine SA, 2005), Youth Advocates Against Family Violence (Inner Melbourne Community Legal Centre, 2013).

Flood and Kendrick (2012) undertook an evaluation of two Australian primary prevention programs: the LoveBites program, developed by the National Association of Prevention Abuse and Neglect (NAPCAN)⁶, and another Respectful Relationships program, which were delivered in parallel to year 7 and 10 students, respectively, in a Sydney secondary school in 2010. Both programs aimed to raise awareness about DFV and sexual assault, and promote gender equality, challenge masculine and feminine stereotypes, and develop

⁶ The LoveBites program is unique in that it is community-driven with specific activities and goals developed by participating students and the wider school community, parents and teachers.

respectful relationships and leadership skills. LoveBites involved a one-day workshop for Year 10 students in addition to student-driven activities and curriculum-based content delivered by classroom teachers, and two “Leadership Days” (delivered to co-ed classes). The Respectful Relationships program, supported by NAPCAN, was delivered to Year 7 students (boys and girls) over 13 weeks facilitated by a Health and Personal Development and Physical Education teacher and focused on “respect, relationships, gender, sexual harassment, bullying and skills building regarding conflict resolution and communication” (Flood & Kendrick, 2012, p. 9). Students and teachers were surveyed before and after participation in the programs. Results of the evaluation were mixed, but largely positive:

The LoveBites and Respectful Relationships programs had a significant and positive impact on students’ attitudes towards domestic violence, attitudes towards gender relations, and skills in having respectful relationships. Students who participated in the two violence prevention programs showed significant improvements in their attitudes and skills in these areas. (Flood & Kendrick, 2012, p. 1)

There was little impact on either Year 7 or Year 10 students’ attitudes towards aggression and alternatives to aggression, and no impact on Year 10 female students’ attitudes towards dating violence, or Year 10 males’ attitudes towards coercive behaviors. The authors suggest the mixed results may indicate that the programs are more effective with some groups than others, but also indicates that some of the data collection methods may have impacted on results, and recommend further evaluation development of similar programs (Flood & Kendrick, 2012).

Fergus undertook an evaluation of the South Eastern Centre Against Sexual Assaults’ Respect, Protect, Connect program (Fergus, 2006) delivered to year 7–10 students across schools in Melbourne’s southeast. The program was delivered to males and females separately with different aims for each of the groups. For young women, the aim was to raise awareness of and define DFV by providing young women with a framework for which to understand DFV and sexual assault, and also to empower them to identify and respond to DFV and sexual assault. For the young men, the aim was to educate and discuss respectful relationships, explore and develop broader understandings of masculinity, and to discuss healthy ways to deal with confrontation. The evaluation assessed the impact of the program on participants, and its adherence to good practice principles. Quantitative results demonstrated clear improvements in attitudinal measures for young men, while young women had showed improvements in the development of support-seeking skills and greater awareness of DFV and sexual assault. The program met all but one of the best practice principles for primary prevention work in schools.

There are limited reviews or evaluations of programs offered in primary school, though NAPCAN is currently piloting a primary school-based respectful relationship program, Growing Respect, based on the LoveBites program, which is in the process of being evaluated (Walsh & Peters, 2011).

5.1.2 Early intervention and response in schools

As discussed in the previous chapters, there are some complexities in distinguishing between primary prevention, and early intervention and response, with regard to the timing

of intervention and the populations targeted. Since significant numbers of children are already involved in violent relationships or exposed to DFV in the home, and children have already formed views on violence and gender by the time they reach secondary school, activities categorised as primary prevention can come, in fact, *after* the event for some children (Ellis, 2008). In light of this, there is some discussion in the literature around the advantage of schools as sites for early intervention and response. As described above, many evaluated violence prevention programs for primary school-age children tend to be based in the social learning theory model (Ellis et al., 2006), or in a protective behaviours or anti-bullying model. They tend to focus on conflict resolution skills and building resilience, and do not often engage with gender as a cause for violence.

Ellis et al. (2006) argued, however, that the social learning model approach may be useful in interventions aimed at children, as long as gender is also addressed in these programs. They argued that this approach can be both universal and specific: those living with DFV can gain support and protection in non-stigmatising way, while simultaneously enabling all children and young people to develop skills, knowledge and attitudes “to conduct non-abusive relationships” (Ellis et al., 2006, p. 70).

Ellis’ review of school-based programs in the United Kingdom (Ellis, 2004; Ellis et al., 2006) suggested school-based programs can serve several functions: awareness-raising about DFV, promotion of respectful relationships, challenging gender stereotypes, and fostering non-violent conflict resolution, as well as providing support for children who may be experiencing DFV. Thompson and Trice-Black (2012) also propose that schools are an ideal location to provide group counselling and play therapy to children exposed to DFV, and additionally act as a “safe and neutral” site in which to develop healthy, positive relationships, gain academic and emotional support, and develop resilience and healthy coping skills. Qualitative accounts of children’s experiences of DFV reveal that children experiencing DFV in the home may view school as a place of refuge (Mullender et al., 2002; Mudaly & Goddard, 2006).

Alexander et al. (2005) conducted group discussions of DFV with 254 children in several primary schools in Scotland. They additionally conducted a questionnaire and asked children to participate in a writing exercise, which canvassed their views and experiences of DFV. The authors argued that the intervention allowed children to safely disclose incidents of DFV (via the questionnaire and writing exercises) and openly discuss DFV in a safe environment. In other qualitative studies, children, teachers and mothers mention schools as ideal settings for therapeutic interventions (Willis et al., 2010; Yates, 2012; Yates, 2013), though there is an acknowledgement that this would require significant investment in teacher training and the provision of specialised counsellors.

The Koorra the Kangaroo program (Bradford & Nancarrow, 2005) is a culturally appropriate targeted primary prevention/early intervention program offered to 4–12 year olds in a Queensland school with an exclusively Indigenous population. Unlike some programs, Koorra the Kangaroo was incorporated into the school’s curriculum. The program aimed to mitigate the effect of potential exposure to DFV among the school population, promote traditional Indigenous cultural values such as respect, and reduce conflict between children. An evaluation of the program found teachers and children felt the program was beneficial, and there were reductions in incidents of conflict between children (Bradford & Nancarrow, 2005).

The All Children Being Safe program (NAPCAN) another evaluated, culturally appropriate primary school protective behaviours program that uses animal stories, craft, dance and other activities to help children aged 5–8 identify safe and unsafe feelings, places and people (Price-Robertson & Higgins, 2012). An evaluation of the pilot program delivered to eight primary schools in Tamworth in 2012 (Price-Robertson & Higgins, 2012) found that the program was associated with an increase in children’s knowledge of protective behaviours and safety, and that both children and teachers found the program valuable and effective, although it was beyond the scope of the evaluation to determine whether participation in the program had increased children’s safety. Like the Koora the Kangaroo program, the All Children Being Safe program did not *specifically* address DFV and did not involve components that challenged gendered stereotypes. However, protective behaviours programs aim to raise children’s awareness of a range of potential harms that could include DFV, and may be viewed as an early intervention.

5.2 Community-based primary prevention and early intervention

There is relatively little evidence on community-based primary prevention or early intervention programs with children in the 0–8 years age group.

5.2.1 Programs for pregnant women and new parents

Pregnancy and early parenthood are recognised as high-risk periods for DFV (Campbell, Garcia-Moreno, & Sharps, 2004; Taft et al., 2013), though there is a lack of evidence for effective interventions for this target group (Taft et al., 2013).

Home visitation programs

A meta-analysis examining the efficacy of primary prevention programs indicated that home visitation programs by nurses or social workers may be effective in reducing DFV among vulnerable families (Chalk, 2000). However, our review found very few studies or evaluations of home visitation programs that were specifically focused on the prevention of DFV. Most are more overtly aimed at the prevention of social isolation, family dysfunction, child abuse and maltreatment rather than DFV, though DFV is often present in the families targeted by such programs (Evanson, 2006).

The Hawaii-based Healthy Start program aimed to reduce DFV via sustained, long-term home visitation (Bair-Meritt et al., 2010). The program involved home visitation from an early childhood specialist over three years (weekly in the first three months) and aimed to educate parents about child development, and model positive parenting. The program also connected families with community support such as DFV services, health clinics, and mental-health specialists. An experimental evaluation of the program found a reduction in self-reported DFV and child maltreatment among participants, compared to a control group (Bair-Meritt et al., 2010).

MOtherS Advocates In the Community (MOSAIC) was a randomised controlled trial of a mentoring program for at-risk pregnant women or mothers with children aged under 5. Participants were recruited from maternal and child health centres and general practitioner

clinics in Melbourne, and were chosen on the basis of having either disclosed DFV or being “psychosocially distressed” (2013, p. 3). The intervention was designed to reduce DFV and depression for participants and strengthen the mother–child bond. Two hundred and fifteen women took part in a 12-month mentor support program involving 12 months of weekly home visits from trained and supervised local mothers (culturally appropriate) who offered non-professional advice, friendship, advocacy, parental support and referrals (e.g., to DFV services). Results indicated a significant reduction in partner violence, but weaker evidence in the reduction of depression and increased parental–child bonding.

Community education programs

Community education programs aimed at new parents are an emerging area for primary prevention strategies (Walden, 2014).

The Baby Makes 3 program was developed by VicHealth and delivered through the Whitehorse Community Health Centre and Warrnambool Maternal Child Health Centre. It is a primary prevention program that aims to increase parents’ and health workers’ capacity to build equal and respectful relationships, and is delivered via a three-week discussion/seminar program covering topics relevant to new parents. It also involves a one-off information session for first-time fathers, and a workforce capacity-building workshop for maternal and child health nurses. An evaluation suggested that participation in the program had allowed parents to become aware of how traditional attitudes to gender and parenting roles were shaping their families, had fostered a greater understanding of gender norms and expectations, and had resulted in a “significant shift in couples’ attitudes characterised by greater understanding of their partners’ role and greater support for gender equality in new families” (Flynn, 2011, p. 2).

5.3 Responding to children exposed to violence

There is a significant body of literature that details the impact of exposure to family violence on children, and some that examines contributors to children’s resilience, as discussed in Chapter 3. However, there is relatively little literature that considers the most effective responses to children who have been exposed to violence. In a review of family interventions for DFV with a child focus or child component, Rizo, Macy, Ermentrout, and Johns (2011) found 31 articles that discussed such programs and evaluated their efficacy. They found discussions of programs that fell into four categories: counselling and therapy interventions; parenting interventions; counselling and outreach interventions; and multicomponent interventions that involved a combination of these (Rizo et al., 2011). There was a significant amount of overlap between the goals of each of these categories of intervention but large variability in how they were delivered. Rizo et al. (2011) found that there was promise that all were effective to some degree. However, given the lack of research overall, as well as within each of these categories, and the variability of strengths of evidence, “it is not yet possible to determine which of these four approaches holds the most promise” (Rizo et al., 2011, p. 163).

In a literature review for the Scottish Government, Humphries and Houghton (2008) provide an extensive overview of the literature on best practice response for children and outline key areas of direction for good practice provision. These include:

- removing reporting to child protection as a first-instance response to children exposed to DFV;
- improving links and collaboration between adult and children’s services;
- developing therapeutic programs that address the mother and child bond;
- therapeutic responses offering both individual counselling and group work; and;
- improving the ability of health workers, teachers and other social service professionals to screen for, identify and respond to DFV (Humphries & Houghton, 2008).

Responses to children should also be culturally and religiously appropriate.

5.3.1 Strengthening the mother and child bond

One of the key findings of the reviews by Rizo et al. (2011) and Humphreys and Houghton (2008), and reflected in the wider literature, was that some of the strongest evidence available on responding to children exposed to violence focused on interventions that address both caregivers (mostly mothers) and children, in order to repair the potentially damaged parental relationship following experiences of DFV (Bunston, 2008; Bunston & Heynatz, 2006; Graham-Bermann & Hughes, 2003; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Humphreys, 2011; Humphreys, Thiara, & Skamballis, 2011; Lieberman, Ippen & Van Horn, 2006; Sullivan, Bybee, & Allen, 2002).

Humphreys (2011; 2014) argues that there needs to be more interventions that focus on both caregivers and children in the Australian context. Humphreys’ analysis is part of a very limited body of literature that considers post-crisis responses to children who have been exposed to DFV in the Australian context. Humphreys (2011) critiques the traditional fracturing of women and children’s services. She argues that adult services need to be better equipped to respond to the needs of children (2014; see also Bunston & Sketchley, 2012; Bell, 2006). Children frequently accompany women to support services (e.g. refuges), but their needs are often not well met there (Bell, 2006; Bunston & Sketchley, 2012; Spinney, 2013). Humphreys argues that these gaps are unhelpful when attempting to support the mother–child relationship, which needs to be actively strengthened in any intervention (2011; 2014).

There are very few Australian evaluations of early intervention or response programs for children. The Royal Children’s Hospital Mental Health Service, in Melbourne, previously delivered several infant/child-led, trauma-informed interventions for children and their caregivers (Bunston & Heynatz, 2006), however they are no longer in operation. Two of these programs, the PARKAS program and the Peek-a-boo Club, were evaluated using extensive quantitative and qualitative methods, and demonstrated improvements in outcomes for mothers and children, as well as overall satisfaction from participants (Bunston, 2008).

5.3.2 Trauma-informed responses

As discussed in chapter 3, the co-occurrence of DFV with other forms of child maltreatment is high (Bromfield et al., 2010; Higgins, 2004; Price-Robertson et al., 2013), and the impacts of trauma on children exposed to DFV have been well established in the literature. As such, trauma-informed care is often recommended in therapeutic responses

to children (Australian Centre for Posttraumatic Mental Health, and Parenting Research Centre, 2013; Bunston, 2008) and is particularly emphasised for Indigenous children who may be exposed to multiple forms of maltreatment (Atkinson, 2013). Atkinson states that trauma-informed care in therapeutic responses:

- “understand[s] trauma and its impact on individuals (such as children), families and communal groups;
- create[s] environments in which children feel physically and emotionally safe;
- employ[s] culturally competent staff and adopt[s] practices that acknowledge and demonstrate respect for specific cultural backgrounds; and
- support[s] victims/survivors of trauma to regain a sense of control over their daily lives and actively involve[s] them in the healing journey.” (Atkinson, 2013, p. 1)

The importance of programs for children being trauma-informed was also reiterated in our stakeholder consultations, as we will discuss in Chapter 7.

5.4 Summary and policy implications

This chapter has examined the key evidence available on best practice for primary prevention, early intervention and response programs/strategies for children. Overall, there is relatively little evidence for efficacy of programs for children and thus recommendations are given with caution. School-based primary prevention programs that address the underlying causes of DFV are endorsed in the literature and recommended through international and national policy frameworks. However, there are very few evaluated programs for children aged 8 and under, as most programs are delivered to secondary school students. A key focus in the literature on school-based primary prevention has been the importance of programs retaining a gendered analysis and understanding of DFV. There is also an emerging rationale in the literature for the use of schools as sites for early intervention and response.

We found very little literature with regard to what types of community-based early intervention programs work with children, though there is some evidence to suggest home-visitation programs in early infancy may be effective, however most programs do not specifically target DFV. Our analysis of responses to children exposed to DFV suggested that therapeutic programs addressing the mother and child bond are central to best practice approaches.

There is a need for further development and support of existing primary prevention programs specifically for primary school-aged children, and these need to be evaluated. Targeted early intervention strategies in schools and community settings also need further research and evaluation and there is scope for protective behaviour programs to better address DFV. The literature suggests that responses to children exposed to DFV should be trauma-informed, address the non-offending caregiver–child relationship, and work collaboratively with adult services.

6 Characteristics of best practice: Insights from practitioners and stakeholders

This chapter reports on the key themes arising from our stakeholder consultations, interviews and the Request for Information. We first examine the broader characteristics of best practice identified by our participants, and then examine specific areas of primary prevention, early intervention and response. Responses from our stakeholders were generally consistent with the literature, with key areas for further funding, research and investment being in the areas of primary school-based respectful relationship education, better post-crisis specialised services for children and therapeutic programs that aimed to restore the (non-offending) parent–child bond. There was strong consensus that approaches to DFV needed to be guided by a common policy framework.

6.1 Practices should be informed by an overarching framework or policy

Throughout the consultation process, participants strongly communicated the view that the DFV sector needed a clear and cohesive framework for understanding, preventing and responding to DFV. Participants believed that an overarching policy and practice framework would better enable the sector’s capacity to work towards shared goals and strategies and better meet the diverse needs of clients.

A clear vision and understanding of the goals to be achieved, an alignment of strategy at all levels—local, regional, state-wide and national. An integration and prevention initiative into overall responses to domestic and family violence. (Roundtable consultation, Sydney)

The VicHealth framework (2007) and the Victorian integrated policy framework were often referred to as exemplar models of cohesive and holistic service delivery.

Consistent with the literature, there was strong consensus among our stakeholders and respondents that a gendered understanding of DFV was vital to informing primary prevention, early intervention and response strategies. A gendered viewpoint was considered necessary both in the understanding that women and children were overwhelming the victims of DFV perpetrated by men, and that prevention work should address the underlying causes of DFV and thus work on challenging gender inequality and community attitudes:

Attitudes to gender equity is, I think, one of the lynch pins to how we can look at prevention work. (Roundtable consultation, Melbourne)

While there was widespread agreement regarding the importance of retaining a gendered perspective in the DFV sector, some respondents also emphasised the importance of recognising the impact of other risk factors, and that these other factors may intersect with, and may supersede, gender for some at-risk groups and children:

It’s like for each of the groups who, you know, are defined as at risk, there is the more traditional understandings of family violence around the gendered

element, and then there's all these other things that interplay. Like you were saying that intersectionality and it is so ... I find it hard enough ... to understand family violence at a very basic sense, let alone when you add all of these other experiences or identities or, you know, parts of your life. (Roundtable consultation, Melbourne)

However, several participants put forth the view that an overarching gendered or feminist perspective could also be encompassed to understand the complexity of DFV experiences in diverse groups. For example:

So that is a real strength in terms of this field and policy because at the end of the day no matter how we talk about it ... how [a] gender analysis helps is around power. So it can be then transferred onto same-sex relationships and that sort of thing but the feminist understanding gives us a real, a firm base to operate from because overwhelmingly women and children are victims of violence perpetrated by men. (Roundtable consultation, Brisbane)

That domestic and family violence is gender-based violence against women and their children. It is a consequence of and cause of gender inequality and how that intersects with other social inequalities such as race, class, ethnicity, sexuality and ability. (Community organisation, Victoria)

Some participants expressed a concern that a gendered framework had been subsumed in some areas of practice, by gender-neutral discourses. This was particularly in relation to school-based prevention work and the family law system. An academic participant in our Melbourne roundtable discussion suggested that some in the education system were uncomfortable using gender as an interpretive framework for DFV prevention work in schools, because of the perception that this would alienate boys:

So I've been researching how teachers and students have responded to that material, and interestingly enough, the issue around male violence in one particular school, there are a number of men who were very uncomfortable with the use of the words, you know, "gender-based violence", or, "crimes against women", and were really happy to be using words like, "respectful relationships". And talking about how disengaged it made the boys, but then when I carried out focus group research with the boys, it was actually not the case, it was more a perception, but it raises issues about how we work ... (Roundtable consultation, Melbourne)

In Brisbane, a participant who was heavily involved in delivering school-based DFV-specific primary prevention programs similarly confirmed there was resistance by some in the education system:

if you have in schools women usually who are looking to bring gender into the conversation, they will be slapped down by and large and I've been through that myself, you know, you have to be very brave and have a lot of support to start having critical discussions about construction of gender, bullying, homophobia, violence and connecting bullying to domestic violence or family violence and sexual assault down the line. So yeah, so it is, it's very hard for schools. (Roundtable consultation, Brisbane)

6.2 Targeted and universal approaches are both important

Reflecting the current policy framework, a strong theme arising from our consultation process was that universal and targeted approaches, at different levels of risk, were necessary for effective delivery of primary prevention programs. A key premise of this view was the notion that primary prevention work could be tailored to meet the needs of diverse groups, including children at risk of exposure to DFV:

There is that model of thinking ... you know ... you look at that triangle, its like how do we put the most energy into that pointy end where there's most at risk, and then you work down that triangle so that there is a universal approach but then you tailor it. (Roundtable consultation, Melbourne)

I think that's you know, a whole of community approach but really targeting the children, but having those, also having the programs for those who have been impacted by domestic and family violence. (Service interview, NSW)

However, this also raised issues around the ambiguity regarding conceptualisations of primary prevention. There was acknowledgement that universal strategies such as school-based DFV prevention have the potential to capture populations that are at risk of experiencing DFV, or already exposed to DFV. But there was also disagreement regarding whether primary prevention programs targeting children at risk of witnessing DFV were actually early intervention or response:

So a primary prevention program is talking about the underlying causes of violence against women, it's talking about gender equity, gender stereotypes and power, which is not to say that other programs don't, there will be a therapeutic basis in some or there will be a referral point in a primary prevention program but it is about trying to maintain the content, and people often talk about early intervention programs as primary prevention and there's nothing wrong, you know, we need all three of those categories of programs and hopefully, you know, we won't need the other two and we'll just need primary prevention in an ideal world, which is not going to happen. But the necessity of kind of maintaining the kind of theoretical understanding of that is really important. (Roundtable consultation, Brisbane)

6.3 Best practice for school-based primary prevention

Several respondents in our consultation process and stakeholder interviews were working directly in the area of DFV prevention in schools. Consistent with the literature, many participants emphasised that primary prevention needed to begin earlier than what was currently happening in the community. There was also a strong emphasis on the importance of primary prevention programs for children being based in a model that prioritised attitudinal change, however there was acknowledgement that this was a “hard sell”, given the outcomes would not be seen until future generations.

Eight is too late. By the time a child is eight years old, their gendered attitudes are pretty firmly established and you're going to have to work hard to change

them because then it becomes group behaviours that reinforce each other and the whole power privilege and entitlement and everything that keeps that moving forward. (Roundtable consultation, Brisbane)

When I started, a lot of people, a lot of workers were telling me that by the time they get their students, so about normally Year 9 and Year 10... And it's often—it's not too late, but it's harder, and I think basically the work that they do is about changing people's attitudes. So not about responding to the violence itself, but about changing attitudes so later on that violence will not occur. (Roundtable consultation, Melbourne)

Attitudes against, around violence and respectful relationships are formed very early, well before secondary school, and maybe even primary school, so just sort of starting as early as we can to sort of start getting that life course approach to, yeah, to these issues around violence and respect. (Service interview, QLD)

As discussed above, there was widespread agreement that primary prevention programs should work within a gendered framework, though there was also often resistance to a gendered approach in the school system.

There was also agreement that primary prevention programs in schools needed to work within a “whole of school” approach, working in consultation with the needs of schools and their local communities. Furthermore, participants agreed that in order for school-based primary prevention to be effective and sustainable, it needed to be part of the national curriculum rather than delivered in various ad hoc or one-off programs. However, there was acknowledgement that this required significant investment in teacher professional development/training:

So if you're going to work with schools, you can't just come in, you know, represent a program, and walk away. It's, it has to be taken by the teachers, the teachers need to be trained, it needs to fit within the curriculum framework, otherwise it's not sustainable. (Roundtable consultation, Melbourne)

Related to this was the concern expressed by some participants that some one-off programs in schools may not have adequate measures or protocols in place for dealing with possible disclosures by children who may be exposed to DFV. Some participants suggested that teachers may not be adequately alerted to this possibility or be aware of procedures to follow in case of this.

There was some discussion regarding the need for primary prevention in schools to be supported by wider public campaigns, as there was the potential for the wider community and/or family attitudes to undermine the work that was happening in schools. For this reason, programs such as LoveBites were thought to be effective as the program involves community consultation and involvement:

it's a care development sort of model and it brings in—so it goes into schools but it brings in a whole lot of people around schools as well, so this idea of community as being part of schools ... So having a dedicated worker fulltime to devote to our region has been critical at building relationships with schools but also with the community. (Roundtable consultation, Brisbane)

6.4 Best practice responses to children exposed to DFV

A strong theme to emerge from the consultation process was the importance for children's services to be child-centred and the importance of children's views being heard. Several respondents and stakeholders suggested that until recently, children were sometimes "forgotten" or overlooked by response services as the main focus has historically been on women:

Well, in my role and doing the project that I'm doing now I think the key learning from that is that with the short amount of time that we provide these programs to the children, we provide a safe, stable space for them to feel heard. You know, quite often I think the big thing in my experience is we address the crisis and that's getting mum sorted you know, in my experience the children are sort of the bystanders and often forgotten and them having their own space, their own safe space to be heard, and that doesn't necessarily mean they tell you everything that happens, but they work through that creative play having that time. Their feeling of importance and them being a part, I suppose, of a group where what they say is heard and taken seriously for that amount of time, I don't know it's just, it amazes me that that can have such a major impact on their emotional and social and educational development. (Service interview, NSW)

The importance of having a trained, children's specialist, not a general counsellor, as part of crisis response services was seen as important:

And before I came here I went and spoke to a couple of our support workers and they just said "we can't tell you how much of a difference it makes for us as staff in our ability to do our role and for the families, particularly the children, to have someone specifically trained and who deals with the children". (Roundtable consultation, Sydney)

As discussed in Chapter 4, the evidence in relation to therapeutically responding to children exposed to DFV suggests that programs should focus on rebuilding the relationship between mother and child, which may have been compromised as an effect of DFV. This was reflected in our stakeholder consultations and there was widespread agreement that services should be trauma-informed and work at repairing the relationship between mother and child:

The (non-offending) parent/carer's attachment relationship with the child/young person is critical to recovery and healing. (Community-based organisation, NSW)

I think that's an important thing to point out, so like working with children individually but also acknowledging the importance of ... working with both the mother and the children to rebuild those relationships, which have [been] disrupted if you like, as a consequence of the experience of violence, so working with children and ... the mother to rebuild the relationship to child. (Service interview, NSW)

More broadly, it was acknowledged that response and therapeutic programs for children should work holistically, that is, addressing all areas of the child’s emotional, social, physical and psychological needs including immediate safety needs. Flexibility, and the ability to meet children’s diverse individual needs, was also a highly valued principle among our respondents:

And also as part of a family unit, so often when they’re dealing with the child, part of that is then fixing the relationship with the mother, helping fix the relationship with siblings and building the families, it’s not just an isolated counselling. But yeah they said—but there’s just very few of them. (Roundtable consultation, Sydney)

And that they work from a—that they’re flexible so they can work outside, you know, the bureaucratic frame and also that they work from an ecological model, so they also are not only client focused but they look at and support and work with all the other systems that surround that child, young person or adult. (Service interview, NSW)

the way that we work, it seems that having a lot of flexibility with the kids in how we work with them ... All of the kids seem to need just slightly, or sometimes drastically, different approaches from people. (Service interview, NSW)

6.5 Summary and policy implications

Our stakeholders and research participants identified several factors important to best practice primary prevention, early intervention and response with children . A central theme, relevant to all areas of DFV service, was the importance of practices being informed by an overarching policy framework that clearly articulates a gendered understanding of DFV. An overarching framework would enable better sector cohesiveness and facilitate better alignment of goals and strategies.

Stakeholders emphasised the importance of implementing strategies that targeted populations on the whole but also highlighted the importance of targeting communities/populations at risk. This view reflects a socio-ecological approach to DFV as adopted in the WHO and VicHealth frameworks, that prevention should be targeted at varying levels of risk, across the lifespan and in various contexts. When considering policy implications, it is important to ensure there is support for both universal primary prevention strategies/programs and targeted programs addressing children most at risk of exposure to DFV.

Several of the research participants and stakeholders were working directly in the area of school-based primary prevention. A strong view to emerge, and consistent with the literature, was the belief that primary prevention should occur much earlier than secondary school, given that children’s views may already be ingrained by the time they reach adolescence. It is therefore important that future investment in school-based primary prevention programs include programs directed at younger children. School-based primary prevention programs should be informed by a gendered understanding of DFV, address

gender inequality, be delivered through the “whole of school” model, be culturally appropriated and include consultation with local communities.

The best practice response to children exposed to DFV was characterised as being trauma-informed, addressing the damaged relationship between mothers and children, and child-centred.

7 Barriers to effective practice with children: Insights from practitioners and stakeholders

This chapter provides a summary of the key issues our stakeholders and research participants identified as acting as barriers to effective practice with children.

7.1 Absence of a clear evidence base

There was widespread agreement that for all levels of the DFV sector—prevention, early intervention and response—practice should be evidence-based. Many participants reflected that there was a need for programs to be rigorously and frequently evaluated, but this was not happening frequently enough:

Rigorous evaluation [is needed] to contribute to the emerging evidence for work in this area and to demonstrate the importance and impact of this work. (Health Service, Victoria)

I think we need an evidence base to provide the essential platform on which to develop effective programs ... So we've just got to really get our act together and start to develop an evidence base in Australia. And I think our evidence base should look at all types of knowledge, empirical knowledge obviously, but also I think we need to be taking account of, you know, the practice wisdom of workers who have been working in the field, personal, theoretical and, yeah, we just don't have the evidence base in Australia for critical levels. (Service interview, QLD)

Several participants expressed a concern regarding the lack of evidence of some programs operating in the sector but acknowledged there was a lack of capacity for services to undertake evaluations:

But there are a lot of good parts of programs but all programs can improve and if you don't have money to put aside in funding agreements to do proper—not internal evaluation—proper evaluation with time expertise, which costs money. (Roundtable consultation, Sydney)

And we talked about the lack of sustainable ongoing funding. And for instance some of the programs of being—like my program was funded for 18 months ... and others for three years. And ... that program is suddenly not needed anymore or that it's completed but in fact you're only just starting a program and you're barely done, you know, you barely pilot it and you probably haven't had time for evaluation. So that the funding model isn't ongoing and sustainable and it doesn't allow proper program development and evaluation. (Roundtable consultation, Sydney)

Inability of services to undertake evaluations was related more broadly to lack of long-term and secure funding.

7.2 Funding

An overarching barrier identified widely by the majority of respondents in our research was a lack of long-term, secure funding. As described in Chapter 1, funding for DFV services and programs is ad hoc and uneven, consisting of federal, state and local government funding, various private sector and government grants, charitable donations and private philanthropic arrangements. The majority of participants in our roundtable consultations and interviews and many respondents to our Request for Information mentioned the lack of ongoing funding as a key inhibitor of effective practice and service delivery. It was widely agreed that in order for funding arrangements to support effective practice, funding needs to be long-term and flexible.

The bureaucracy surrounding and the structure of current funding arrangements, as well as the limited availability of grants and funding, was commonly raised as a significant concern. It was often suggested that current funding arrangements create tension between services competing against each other for a limited pool of funding. At times, this may compromise the capacity for multi-agency service collaboration in the sector:

I think some of the other inhibitors are sort of the competitive nature of the way in which services get pitted against each other. (Stakeholder consultation, Sydney)

But you—you feel like you’re competing ... And I think the reality is we all have so much to offer, so how do we—how do we harness that as opposed to, oh, like let’s all compete for that one thing and we’ll knock each other over on the way to get to that one little piece. (Roundtable consultation, Melbourne)

The short-term nature of many funding arrangements was also seen to act as a barrier to effective practice and inhibit the sustainability of programs. For instance, it was often suggested that “good programs” are piloted but then never have the opportunity to be delivered again due to shortages of funding:

Because it just gets a bit frustrating when you can see there’s a number of really great programs happening across different areas that have been driven from the ground up ... but then whenever there’s a new policy push from ... a government, there’s a whole new, brand new, shiny sort of program that’s got that infrastructure in place and it’s not within local communities and it just seems ... well it can be quite frustrating. (Service interview, NSW)

Further to this, was the idea that services and organisations were “constantly reinventing the wheel” (Melbourne, Roundtable consultation) at each new funding cycle. It was thought that the instability of funding contributed to evidence and knowledge of effective programs and practices being lost. This was also related to the inability of organisations to undertake evaluations as a result of insufficient funding.

Other ways lack of funding was thought to inhibit the capacity for effective practice:

- Services have to prioritise women and children who are less safe at the expense of helping *all* women and children who approach organisations.

- The paperwork and hours involved in applying for grants and funding, lobbying government departments, or in maintaining relationships with philanthropic organisations/individuals is time consuming and detracts from the service provision;
- The inability to meet the needs of clients.
- The inability to undertake primary prevention work as funding is funnelled into those most in need.
- Women and children being turned away from housing or refuge services. This shortage of emergency housing may be causing women and children to remain in violent situations.

7.3 Shortage of child-centred therapeutic response services

As outlined in the previous chapter, the importance of child-centred programs and services in the DFV response sector was considered essential to the efficacy of programs. However, several respondents highlighted the shortage of child-centred services, particularly in rural and remote areas, and existing services having long waiting lists:

Like some of the comments we've had is, "I don't know who to go for help because I've spoken to the teacher and they've done nothing". You know, so that's one of our biggest things is falling through the gaps in that regard but also we work a lot with disengaged children and youth. So if all of the counselling is at school which a lot of it is, it's not open on weekends, it's not open after hours, it's not open in holidays and if they're not attending school or childcare or whatever, they're not actually going to ever turn up on the radar. So I mean our big push is trying to get therapeutic services at the zero to eight group, it's almost non-existent. Our program which is 64 last year, it's only a small program but it's one of the only and we're over subscribed, we've got waiting lists, there's just a real lack, you know, of therapeutic services for particularly zero to eight, but even youth. (Roundtable consultation, Sydney)

One of the reasons cited for a shortage of spaces in existing counselling services was that many specialist therapeutic services are only accessible to children where there has been a substantiated child protection claim:

If they don't meet other particular criteria of mental health or child protection they can't fit a service so there's no way for those children to receive counselling or support. And those services that they do accept ... often don't provide a holistic, i.e. don't see the family, and don't work in an ecological model because there's no resources to do that and they're not supported to do that. (Service interview, NSW)

Further to this, was the view that schools, pre-schools/childcare services and allied health services were ill equipped to respond to and identify children exposed to DFV. There was a view that children were "falling through the gaps" (Sydney, Roundtable consultation) and it was thought that there needed to be an increase of sector training and capacity building for health workers and teachers and other child services (e.g., maternal and child health nurses):

Because everybody is seeing it as just a one agency business and not everybody's business. And that comes from the top, I think agencies, I think that needs to be promoted more, that it's everybody's business and everyone of us has the potential to come into contact with women, children and families. Yeah, and until that's changed in policies across the board and all that, I don't think we're going to get such a big impact, but the same people—it's like preaching to the converted. (Service interview, NSW)

Some participants argued that mental health professionals were not linking common behavioural problems with potential DFV or child abuse. There was the suggestion for further professional development and training in DFV issues and recognising symptoms of DFV.

7.4 Problems arising from the intersection of child protection, family law and DFV sectors

As discussed in Chapter 2, the intersection of DFV polices, child protection and the family law system, and the potentially negative impact that the gaps, overlaps and inconsistent approaches have on women and children, has been well established in the literature (Hart, 2011; Higgins & Kaspiew, 2011; Humphreys, 2014; Powell & Murray, 2008). Several stakeholders and participants raised concerns regarding the intersection between child protection, reporting DFV to police, and seeking assistance for DFV from support services. There were concerns raised that mandatory reporting of DFV in some jurisdictions (see discussion in Chapter 2) may result in women not seeking police assistance in DFV situations, as they fear being reported to child protection, and/or being held accountable for the violence. DFV workers also expressed a reluctance to report to child protection:

And if children are involved they're scared that their children will be taken away from them. So they're victims and then they're punished by failing to protect their children when they don't have control over that. (Roundtable consultation, Brisbane)

I've been working within this field for ten years now and I would say my biggest frustration is the amount of responsibility that is placed on the women or non-offending caregivers when there's domestic violence raised as an issue through the child protection authorities. (Service interview, NSW)

Some participants in our stakeholder consultations identified an ideological or theoretical clash between what were perceived as feminist DFV services and child protection services, which in turn shaped the way services responded to children experiencing DFV:

We very much work on the framework of childhood development and infant mental health and I think that this is something that I—we sort of tend to experience a little bit—it's somewhat of a theory clash between child protection and feminist theory. And the challenge that that's about for us is that if there's domestic and family violence in the home, mum being a victim of that, there's still active child protection concerns, of where we need to often inform Child Safety about that happening, we're finding from the domestic

and family violence services that they're not reporting or under reporting those incidences and there's continuous discussion around that. I'm not sure—I'm not sitting here with any specific strong framework of what that looks like but I think that it's something that probably needs to be addressed at some point in how do you actually sort of then work with families, they can be quite conflicting. (Roundtable consultation, Brisbane)

Another related theme to emerge particularly strongly in our Queensland consultations was around the family law system and concern for the safety of children during and after separation. Issues were frequently raised in regard to courts allowing fathers with a history of DFV access to children. There was the strong view that children's safety was being compromised because of a lack of integration between DFV policies and the family law system:

Children have a whole range of responses to the ones that they've experienced via separation, a whole range of experiences during that period, but you then can't assist a child to come up with new ways of thinking about what's happened to them and to process the violence that's occurred, to talk about respect, to do any of those things if they're continuing to be abused or even just exposed to the person who continues to hold within themselves ideas, beliefs, attitudes that are inherently violent. (Service interview, QLD)

The Family Law Courts are continuing to place children at risk by placing them in the care of an abusive parent despite the children's disclosure of family violence, sexual assault and, again, that's been dismissed as the result of manipulation by a protective parent or grandparent or family member. (Roundtable consultation, Brisbane)

7.5 Summary and policy implications

The key issues raised in regard to barriers to effective practice centre on an overall lack of Australian evidence across the board, and relatedly, a lack of consistent, secure funding. When considering policy implications, it is essential that we build a strong evidence base in Australia through the evaluation of existing programs, and through the funding of future programs to include an evaluation component. Competition among services/programs over limited funding was commonly highlighted as a significant concern. It was thought by some, that this might compromise the capacity for multi-agency service collaboration in the sector. Limited and inconsistent funding was also thought to contribute to an inability of services to deliver programs past the pilot stage and an inability to include an evaluation component to programs. Concerns were also raised that a lack of funding inhibited the sector's capacity to respond effectively to women and children's needs, for instance being forced to prioritise those most in need. Longer and more secure funding cycles would alleviate some of these issues.

A gap in service provision was identified in the area of child-centred therapeutic counselling services for children under 8 years of age, with many existing services said to involve long waiting lists or requiring substantiated child protection claims to be eligible. There is a need for more therapeutic, post-crisis services for children. There was also acknowledgment that allied health services, schools and early education services were not

trained to understand, recognise and effectively respond to children exposed to DFV, signalling a need to support sector capacity-building in the areas of health and education.

Finally, a key theme to emerge, particularly in our Queensland consultations, was around the issues that arise from the intersection of DFV polices, child protection and the family law system, and the potentially negative impact that the gaps, overlaps and inconsistent approaches have on women and children. In particular, stakeholders expressed ongoing concern for the safety of children during and after separation. Some stakeholders also reported that some people who experience DFV might be hesitant to disclose those experiences to professionals or seek police assistance in DFV situations, because of a fear of being reported to child protection, and/or being held accountable for the violence.

8 Overview of Australian DFV programs for children

In this chapter we provide a descriptive overview of the programs identified through our literature review, stakeholder consultations, service-mapping exercise and Request for Information. Internet searches were also undertaken as part of the service review process. This review does not provide an exhaustive account of DFV child-focused services in Australia, or in any particular state. A focus on NSW and Victoria was adopted because of the need to consider programs in NSW, in particular, and the extent of development in approaches in Victoria. Most of the services that engaged in our stakeholder consultation and responded to our Request for Information indicated that they undertake work that could be understood as primary prevention and/or early intervention and these were undertaken in a range of contexts. They are not necessarily undertaken separately from other types of responses, such as crisis and therapeutic services. As discussed in previous chapters, this blurring of boundaries between tertiary, secondary and primary prevention activities is widespread in the DFV sector. Moreover, women and children's services were rarely distinct from each other; aside from primary prevention programs, most programs are delivered through services targeting both women and children. Examples are given in each section of the types of programs that are available and whether they meet some of the best practice approaches outlined in the previous chapters and whether they are informed by a clear program logic/theoretical base. There is not enough evidence of efficacy available, however, about any one approach to make a clear or definitive statement about whether the programs are exemplar models. To recap, some of the key best practice approaches identified through our literature review and stakeholder consultations were:

- school-based primary prevention should be informed by a gendered understanding of DFV and aim to challenge gender norms, be culturally appropriate and employ a “whole-of-school” approach;
- responses to children exposed to DFV should be trauma-informed, child-centred, and address the non-offending caregiver–child relationship;
- response programs should be holistic and integrated collaboratively with adult services; and
- target those at risk (such as children already exposed to DFV or at higher risk of being exposed to DFV) as well as the general population.

For a full overview and list of programs we identified, see Appendix 1.

8.1 Therapeutic programs

The large majority of services we identified were tertiary response services providing individual and group counselling to children. Therapeutic programs consisted of both individual counselling and group work for children exposed to DFV. Many therapeutic programs on offer for children run over a period of time (generally 3–12 weeks) and usually involve a psycho-educational aspect and/or group-based art, dance or other creative activities, in addition to more structured individual counselling. Most programs are

informed by a theory of trauma (see Chapter 5) and aim to build resilience and self-esteem, and allow children to work through their experiences of DFV.

Many group-based programs offered to children exposed to DFV are based theoretically in a social learning theory or the intergenerational transmission of violence theory and specifically aim to counter the intergenerational transmission of DFV through psycho-educational activities. For example, the Way of the Warrior (for boys) and Way of the Washu (for girls) programs for Indigenous children aged 8–12 exposed to DFV, delivered through various services in Victoria, works to develop children's coping strategies and anger management, as well as improve their self-confidence through martial arts other activities (McAuley, 2008). The program offers Indigenous children an:

opportunity [to] learn how to develop solid relationships, offer alternatives to dealing with issues such as anger, anxiety, body image, boundary setting, appropriate age behavior and connecting back to their culture in a healing capacity through positive role modeling. (McCauley, 2008, p. 30)

In an internal evaluation in 2008 (McCauley, 2008), child participants, parents and support workers noticed improvements in children's confidence and behaviour at school. The program was thought to give children a chance to express themselves, gain life skills and develop connections with their cultural community (particularly for children who had spent time away from Indigenous culture in foster care or state care). The program is culturally appropriate and targets a population at risk (Indigenous children who have been exposed to trauma, DFV, and other forms of maltreatment).

The Wilmah and Campesie Women's Refuges in New South Wales, run the Speak Out For Kids program, for children aged 5–7 years and the Kids Can program, for children aged 8–12. Both programs are trauma-informed, and delivered through creative arts therapy, educational activities and counselling:

We do three groups per week so we do a creative arts therapy group which is based on the latest neuro-development research around providing positive neuro-pathways for their experience of trauma so that age group is five to seven and it's all creative arts through the breathing exercises and it's around expressive play and the sensory thing that we do with them, but we also go from that on in to a—it's called Kids Can and that's from eight to 12 years, so within the Kids Can it's sort of a cross between educational and a therapeutic group so we do, you know, it's a lot of building their self-esteem and confidence. We talk about protective behaviours. We talk about the impact of domestic violence so we actually name that a program, but we do the creative side of it as well with different arts and crafts around telling their story through play, and with a lot of those children who attend those groups we try to link mum in with the women's group that we run. (Service interview, NSW)

This program is trauma-informed, child-centred and culturally appropriate. Wilmah and Campesie Women's Refuge also delivers programs and activities to mothers, which aim to increase mothers' parenting capacity and develop their ability to support their children.

A significant proportion of the therapeutic programs identified for children run in conjunction with programs for mothers and focus on repairing or rebuilding the

relationship between parent and child through intensive therapy, group activities and supported playgroups.⁷ For example, the *Building Resilience in Children* program, based in regional New South Wales, is a trauma-informed service providing individual counselling and group therapy for mothers and children and aiming to provide the conditions for optimal developmental outcomes for children:

The project works closely with the non-offending parent/carer(s) to support and educate them about parenting in the context of domestic violence. Relational parenting support is provided using established and evidence-based programs ... Relational parenting programs are used as they have been found to be more effective in strengthening both parental empathy and the attachment relationship. (*Building Resilience in Children, Request for Information*)

Another example, the Children and Domestic Violence Support Group, delivered by the Parramatta Community Health Centre, provides a nine-week therapeutic support group for mothers and children helping them to understand their experience of DFV, strengthen maternal bonds, increase communication, coping and conflict resolution skills, and learn how to appropriately deal with anger.

8.2 Primary prevention programs

Although the literature review suggested there were very few primary prevention programs for young children, we identified several emerging school-based programs. As described in the previous chapter, evidence for effective primary prevention targeting children and young people should address gender inequality and gender stereotypes, and focus on encouraging respectful relationships. Many programs we identified are theoretically driven, and meet best practice frameworks for primary prevention in schools (Carmody et al., 2009; Flood et al., 2009). As such, they are aimed at attitudinal change, addressing gender inequality and gender stereotypes, raising awareness of DFV, fostering acceptance of diversity, and encouraging non-violent social norms by enabling children to develop skills in resolving conflict and rejecting violence in all forms. However, there was also a broad crossover in the work that these programs did; for example, some were specifically targeted at preventing DFV, while others were delivered in the context of anti-bullying or sexual health programs.

Programs are developed and delivered through various services including DFV crisis response services, women's health services, community organisations, child abuse prevention services, and welfare organisations such as the YWCA, and delivered mostly in classrooms. As discussed in the previous chapter, it is strongly argued in the literature and supported in policy frameworks, that primary prevention with children should address the root cause of DFV and thus be theoretically driven by a gendered understanding of DFV, focusing on attitudinal change.

⁷ Supported playgroups are informal playgroups in which mothers and children take part in therapeutic play activities facilitated by a social worker or psychologist (Bunston, 2008).

In Table 1, we outline the various prevention programs identified through our literature review, Request for Information and stakeholder consultations, and the theoretical framework they work within (if known). We did not include protective behaviours programs or anti-bullying programs where they did not also address DFV and/or aim to change attitudes to gender and challenge gender stereotypes. This is not an exhaustive account of primary prevention programs available for children aged 8 years and under, and we do not make any comment on the efficacy of the programs as very few have been evaluated. As noted above, however, most programs that we identified met the best practice principles of school-based primary prevention.

Table 1: Australian primary prevention programs for children aged 0–8

Name of program	Target age/level	Framework or approach	Org.	State	Aims	Evaluated?
Respect, Communicate, Choose	Primary school children aged 8–12	Gendered, Whole of school	YWCA	ACT	Primary prevention of DFV and sexual abuse through respectful relationship education and promotion and awareness of gender equality	No
SUPA Kids Program	Primary school children Prep-6	Whole of school	Domestic Violence Prevention Centre	Qld	Classroom-based education to raise and explore safety, understanding of self and others, positive and respectful relationships, angry feelings	No
Growing Respect	Pre and primary school children	Gendered, whole of school	NAPCAN	Qld, NSW	Promote healthy and respectful relationships, promote non-violent social norms, and challenge gender roles and stereotypes	In process
Bursting the bubble (website)	Children and youth	Education, awareness-raising	Domestic Violence Resource Centre	National	Interactive website aims to help children and young people identify DFV, child abuse, sexual abuse and get help	No
Living in Harmony Kidz Biz	Primary school children	Gendered	North Yarra Community Health	Vic.	Aiming to build lasting change in attitudes towards respectful relationships among primary school children in the Richmond housing estates	No
Solving the Jigsaw	Primary school children	Gendered, Anti-bullying	Centre for Non-Violence	Vic.	To create a culture of well-being and resilience in schools by addressing gendered violence and bullying	No
SECS (Sexuality, Education and Community Support Program)	Prep–12 students	Sexuality education, anti-bullying, gendered, whole of school	Barwon Health	Vic.	Sexuality education model that relies on community participation. Covers gender, power, equality, respectful relationships	Yes (Ollis et al., 2011)
Koora the Kangaroo	Primary school Prep-6	Whole of school, anti-bullying, social learning theory	Queensland DFV Resource Centre	Qld	Provide a culturally appropriate violence prevention and cultural education program aimed at addressing the high rates of violence, dysfunction, lack of respect for culture and Aboriginal elders at Woorabinda State School.	Yes, (Bradford & Nancarrow, 2005)
Respectful Relationships	Children in grades 2–6 and high school students in years 7–9	Whole of school, gendered	Youth and Family Services (YAFS)	Tas.	Promote healthy, respectful and safe relationships, explore the concept and use of respect, encourage positive communication and assist students to develop self-care and rapport with peers, adults, the school and wider community.	No

There are several promising, but as yet unevaluated, programs that meet the recommendations and policy frameworks for best practice in primary prevention. YWCA in Canberra delivers the Respect, Communicate, Choose program that is funded under the *National Plan*. The program targets children aged 8–12 years in Canberra primary schools with in-class activities that focus specifically on understanding gender, sexism and homophobia. Similarly, in Tasmania, Youth and Family Focus (YAFF), a community organisation, delivers respectful relationship programs in local schools for grades Prep-6 and years 7–9, using interactive learning activities designed to promote healthy, respectful and safe relationships, foster respect and understanding of diversity, including gender, racial, ethnic and sexual diversity, develop conflict resolution skills and enhance emotional intelligence in students (YAFFS, 2013). NAPCAN is also piloting a primary school-based respectful relationship program based on the LoveBites program. Growing Respect is culturally inclusive and involves community and school consultation in order to tailor activities to suit the needs of individual schools. Activities vary according to age group, however the general aims of the program are to:

challenge and change attitudes and beliefs about gender, sexual assault and relationship violence. A major focus of the program is the promotion of critical thinking about relationships, violence and gender, empowering children and young people to challenge and change the way they respond to community and societal attitudes and beliefs around gender-based violence. In both the primary school and high school, the program explores how to be an active bystander and challenge violent supportive norms. (Walsh & Peters, 2011, p. 20)

Some primary prevention programs are directed at children identified as at-risk. For instance, the Koora the Kangaroo program, discussed in the previous chapter, is an evaluated whole of school curriculum-based program delivered to a school with an exclusively Indigenous population (Bradford & Nancarrow, 2005). Solving the Jigsaw, in Victoria's Loddon-Mallee region, delivers targeted and universal programs to primary schools to teach empathy, respectful relationships, problem solving and conflict resolution, as well as encouraging children to challenge violence in all forms (Stevenson, 2011). Although Solving the Jigsaw is an anti-bullying program, its underpinning philosophy takes a “political stance” that contextualises bullying in a “social and cultural context ... that allows examination of imbalances of power and responsibility in society” including imbalances of power in the context of “gender, race, and social class” (Stevenson, 2011).

In addition to programs aimed at children, we have also included in this review, primary prevention programs focusing on pregnant women and parents of very young infants. Pregnancy and early parenthood are identified as periods of greater risk of DFV for women and children (Campbell, et al., 2004; Taft et al., 2013) and a population identified by the *National Plan* for increased prevention work. The Whitehorse Community Health Centre's Baby Makes 3 program in Melbourne, developed through VicHealth and evaluated in 2011 (Flynn, 2011) is a program “promoting equal and respectful relationships between men and women during the transition to parenthood” (Flynn, 2011, p. 1). As described in the previous chapter, the goal of the program is to increase parents' and health workers' capacity to build equal and respectful relationships and is delivered via a three-week discussion/seminar program covering topics relevant to new parents. It also involves a

one-off information session for first-time fathers, and workforce capacity-building workshop for maternal and child health nurses. The evaluation suggested that participation in the program had allowed parents to become aware of how traditional attitudes to gender and parenting roles were shaping their families, a greater understanding of gender norms and expectations, and had resulted in a “significant shift in couples’ attitudes characterised by greater understanding of their partners’ role and greater support for gender equality in new families” (Flynn, 2011, p. 2).

8.3 Case management services

Case management services work directly with children and families and aim to provide holistic, integrated and individual responses to DFV. Such measures may include: housing support; safety plans; home visitation services; supporting children’s continuing education; and linking families in with other services such as counselling, health/allied health services, social workers, and parenting support services. Many case management programs work with the whole family (including the perpetrator in some instances) while others focus on the child as the primary client. For example, the Bright Futures program in Victoria, delivered through Merri Outreach Services, provides enhanced casework for children experiencing homelessness and/or DFV. The program offers three streams of support: assessment and case planning; enhanced case management; and therapeutic group work:

Our program is a child-centred model, which is not often seen. This means children are our clients, and work with the parent/caregiver is in relation to the case plan for children as opposed to a family model. Co-case management is crucial to this as it means the referring worker staying involved to support the parent/caregiver and broader family needs, allowing our program to focus on the child’s needs. (Bright Futures, Request for Information)

Berry Street, also in Victoria, offers a holistic model of response and casework working with women and children to provide advocacy, financial counselling, court support and therapeutic programs (Stakeholder consultation). The Children Ahead program in Victoria is delivered by not-for-profit organisation The Alannah and Madeline Foundation and provides individualised support to children exposed to trauma (DFV and other trauma), working with children in their homes, schools and communities over a period of up to two years:

Through regular outreach visits, our qualified social workers work with the children and youth to address the impact of the violence on all areas of their life—to develop social skills such as conflict-resolution and communication skills (often changing generational patterns of dealing with conflict), manage their strong emotions, their physical, mental and emotional health, develop talents and abilities through linking them into community activities such as soccer, gymnastics, swimming, school camps, etc. (Children Ahead, Request for Information)

The Children Ahead program is holistic, child-centred and trauma-informed.

8.4 Early intervention services

Several of the services that responded to our Request for Information and partook in our consultation process were early intervention programs. Some therapeutic services for children exposed to DFV also self-identified as early intervention, rather than response, as they aim to break the cycle of intergenerational violence through psycho-educational therapy. As discussed earlier, distinguishing between primary prevention, early intervention, and response is sometimes difficult and depends on the theoretical approach taken. Early intervention programs/services are generally aimed at at-risk or vulnerable families from pregnancy or infancy and are often delivered through government departments and, less often, through not-for-profit organisations and charities. Early intervention services address the risk factors associated with DFV such as socio-economic disadvantage, social isolation, substance abuse and mental ill-health, often working with families in their own homes, in order to foster resilience, strengthen family bonds, promote good parenting practices, and support families to access educational and social services such as play groups and childcare, social workers or counsellors, and allied health services, with the aim of reducing future social problems including DFV.

ACT for Kids in Queensland delivers an early intervention family support program for families identified as at-risk. In conjunction with other community services, including child protection, the program works with the whole family to overcome issues that may put children at risk, such as social isolation, mental health, addiction and DFV.

Elizabeth Hoffman House, a DFV service in Victoria, delivers the Keeping Booris Safe program, also supported by VicHealth, which is delivered to young Indigenous mothers. The program provides a series of education workshops around rights, responsibilities and support around family violence health-related issues, as well as a 20-week playgroup for mothers and their children. The program aims to raise awareness of the impact of family violence and educate and engage young Indigenous women and children in further activities and support services. Aboriginal organisation Gunawirra Limited runs Family Project, a program aimed at at-risk pregnant mothers. The service features weekly home visiting and 24-hour support and supervision from qualified professionals. **Both these programs address the mother-child relationship and aim to empower and educate young mothers.** The evidence regarding the effectiveness of DFV prevention programs that empower and educate women is still emerging, but it is promising (WHO, 2010). Prevention and early intervention initiatives aimed at women are not a comprehensive response to DFV. We acknowledge the need for prevention and early intervention activities aimed at women to be delivered in conjunction with initiatives aimed at perpetrators, however these programs are addressed in the parallel study undertaken at the University of Western Sydney.

8.5 Sector capacity-building

Some services work indirectly with children and families to build the capacity of services such as schools, early education programs, refuges, and health services to identify and respond to the needs of children exposed to DFV. For example, the North West Regional Children's Resource program in Melbourne assists the homeless sector in identifying the specific needs of children made homeless due to DFV, and the Salvation Army's

nationwide Safe from the Start program provides women's refuges with training and children's resources to meet the needs of children in refuges (Spinney, 2013)

8.6 Summary and policy implications

The large majority of services we identified were therapeutic programs providing support for children exposed to DFV. Therapeutic programs varied in content but generally involved psycho-educational activities aimed at addressing the intergenerational transmission of violence through various strategies designed to develop children's resilience, self-esteem and conflict-resolution skills. Many programs worked with both the non-offending parent and child through groupwork activities and individual counselling designed to address the potentially damaged parental bond. **As noted by our stakeholders in the previous chapters, however, there is a shortage of these programs with demand outstripping availability of spaces; as such, further support, investment and development of these programs is needed.**

Very few of the therapeutic programs are evaluated, though most are informed by a clear program logic or theoretical framework. Addressing the intergenerational transmission of violence seems to be a common goal of therapeutic groupwork programs for children, though whether this is effective or not, is not well established in the literature.

We did not identify any programs specifically aimed at children from CALD or refugee communities and this is a significant gap in service provision.

Primary prevention activities for children in the 0–8-years age group consisted entirely of school-based programs. Although the literature review revealed very little in this area for primary school-aged children, several emerging school-based programs were identified and many met the recommendations for good practice in school-based primary prevention; they were based in a whole of school approach, they addressed gendered dimensions of DFV, and they were aimed at creating lasting attitudinal change. **Very few of these programs are evaluated, however, and there is an urgent need for evidence to be generated on the efficacy of such programs.**

Early intervention activities were less common (although many therapeutic programs for children exposed to DFV often characterised themselves as early intervention). They mainly consisted of programs addressing risk factors associated with DFV, such as social isolation and mental ill health. Pregnancy and early motherhood is identified in the literature as high-risk periods for infants and mothers, however we found very few early intervention programs targeting this group. **When considering policy implications, it is important to consider investing in/supporting early intervention programs for pregnant women and infants.**

9 Evaluation framework for exemplar projects

9.1 Overview and context

This chapter sets out the elements for an evaluation framework for future prevention programs, consistent with the fourth aspect of the project requirements. This element of the project raises some complex issues. Although the features of potential prevention programs are identified in Chapter 5, the scope and budget of any such programs are at this stage undefined. For this reason, the framework set out in this chapter outlines the principles that should be applied in any such evaluation and identifies more specific potential approaches that may be applied in any particular instance. Further, any evaluation that takes place within the parameters outlined here needs to take account of evaluation activities occurring under the Domestic and Family Violence Reform Evaluation Strategy in *It Stops Here*.

As discussed in chapter 2, the field of violence prevention is in an early stage of development. Limited empirical evidence exists on the kinds of approaches that are effective, and significant challenges arise in assessing such approaches, particularly for children in the 0–8-year age group. There are several challenges that are relevant in this context, some of which are conceptual and methodological and others that are practical. From a conceptual standpoint, it is acknowledged that the measurement of the impact of prevention initiatives is inherently difficult because what is being measured is the absence rather than the presence of certain phenomena (DFV), and there is no certainty that they would have occurred in the absence of the prevention measures.

Further, the intended impact of such programs is often wide and relatively non-specific. Some programs are intended to have shorter-term effects but the impact of others is intended to be longer term and attitudinal. Any effects of the program might well not be evident for a significant amount of time. Even if they do become evident, it may be difficult to determine the extent to which effects consistent with the intention of the program are attributable to the impact of the program or other developments, including individual circumstances and broader social influences. The corollary of this is that the absence of effects inconsistent with the intention of the program may also be attributable to issues other than the failure of the program to achieve its objectives. These issues are particularly relevant in the current environment in Australia, where a number of prevention initiatives are being implemented at federal, state and local level, including those such as the Australian Government program The Line and others identified in this report.

From a practical perspective, the other challenges that arise in the evaluation of family violence prevention programs arise from the funding and organisational context in which these programs are embedded. As spelt out in section 5.2.3, often such projects are funded out of specific purpose grants emanating from a variety of sources, including federal, state and local government grant programs and grants tied to specific purpose organisations, including philanthropic organisations. Often these grants have a short lifespan.

The value of and need for evaluation of violence prevention programs is well recognised (WHO, 2010; VicHealth, 2007; Flood, 2013) because of the emergent nature of the policy, practice and body of knowledge in this field. Such evaluations not only support sound

funding decisions but they add to the body of evidence on violence prevention by developing practice-based knowledge. This is one of the arguments for building evaluation funding into program funding packages.

The level of grant funding and the life of the program may provide limited scope to do evaluation, and any such evaluation may occur on a very modest basis (Flood, 2013). So called “gold-standard” evaluation approaches involving external evaluation experts and methods based on experimental design (based on two groups—one that receives the intervention and one that doesn’t) are often out of reach, not just for financial reasons but also because a control group may not be readily identifiable for some programs (Flood, 2013). For this reason, the value of smaller scale evaluations has been emphasised in the family violence prevention literature, along with recognition of the importance of supporting programs to develop the capacity and expertise to evaluate their own programs. Such approaches are recognised to have a number of advantages including supporting the development of empirically informed reflexive and self-critical or self-aware practice.

A significant direction in the literature on evaluation of family violence prevention programs, notably in recent reports produced by VicHealth (Flood, 2013; Kwok, 2013), is the endorsement of “empowerment evaluation” where the agencies and staff implementing programs are supported to perform their own program evaluations. The main justifications for this are twofold: first, that prevention initiatives are often implemented by community-based organisations with limited resources, including very limited resources for evaluation. Thus prevention is seen as a community-driven responsibility and the context and purpose of evaluation activities are based on self-reflective practice and ongoing improvement in program development (Flood, 2013). Second, empowerment evaluation is seen as a capacity-building exercise in which program staff become skilled not only in delivering their programs but in assessing and evaluating program effectiveness, thus supporting “self-determination” in the family violence prevention field.

This direction has emerged in a policy and funding context where an agency—VicHealth—has implemented a focused primary prevention program supported by a comprehensive framework (VicHealth, 2007) for the past seven years. VicHealth has thus developed a philosophy and infrastructure to support a direction of this nature and worked intensively with the agencies delivering programs to equip their staff to conduct these kinds of evaluations. This approach to evaluation is thus embedded in a particular policy and organisational context designed to support this direction.

In the absence of these conditions in the NSW context, and in light of the developing nature of practice and knowledge in the prevention field, the choice of internal or external evaluation for programs for 0–8-year-old children needs to be considered carefully. Because these programs work directly with mothers and/or children, a rationale for internal evaluation arises from the relationships of trust and familiarity that develop between the professionals who deliver the program and the mothers and children who use it. Such relationships support positive dynamics from a data collection perspective.

However, there are other rationales for supporting external, rather than internal, evaluations of new programs or programs that are being funded but have not yet been evaluated, depending on the size of the funding package. External evaluation is independent and this will ensure the evaluation is informed by the exercise of objective

judgement. This is important for three reasons. First, the judgement exercised by the evaluators will not be influenced by any interest in whether or not the program continues. Second, the evaluators have a professional distance from the program and are thus able to consider professional practices, attitudes and dispositions from a neutral standpoint. Nonetheless, working with professionals in the program to develop an informed understanding of professional practices, attitudes and dispositions is important. Third, distance from the program and the professional and client relationships within the program means that data from professionals and clients will be gathered by a neutral third party, and will not be affected by any existing relationships and dynamics within the program and its client group. It is important that such dynamics are examined from an external rather than internal perspective. Having said that, it is acknowledged that the programs in the areas being considered may raise issues of particular sensitivity arising from the circumstances of the client group, and it is important that the evaluators work with the program professionals to ensure that these sensitivities are dealt with appropriately.

For new programs, planning for the evaluation should begin with planning for the implementation of the program. External evaluation should be implemented in a collaborative manner, with the evaluation team working closely with the program implementation team.

The nature of evaluation strategies adopted will depend on the aim of the evaluation. Formative evaluation refers to the process of examining a program or initiative in its pilot or developmental phases with the intention of using the evaluation information to refine the final form of the program or initiative. Summative evaluation refers to examining the impact of a program or initiative. Further, evaluations may focus on processes or outcomes. Process evaluations examine the impact and effectiveness of the processes applied in a program. Outcome evaluations focus more specifically on the result achieved by the program. Decisions in relation to the nature of the evaluation approach applied are informed by which of these foci is the core purpose of the evaluation. Some evaluation designs may include all of these elements.

Principles and implications

- Careful consideration should be given to the question of whether evaluation is carried out internally or externally. In programs for mothers and children, the development of trust and familiarity with program staff may support a decision in favour of internal evaluation. Planning for the evaluation should commence with planning for program implementation. If external evaluation is chosen, it should be planned and implemented in a collaborative approach with the program staff. A collaborative approach will not only ensure the program's aims and context, and appropriately reflect these in the evaluation approach, but can support capacity building for reflective practice in the future.
- The scope and nature of the evaluation should be proportionate to the funding package for the program. Larger funding packages require a more rigorous evaluation approach.
- Internal evaluation may be an appropriate approach for programs that are being funded to expand and have previously been externally evaluated.
- Internal evaluation on a regular basis should be supported when a program is out of its establishment phase.

9.2 Evaluation methodology

The following sections set out the steps and approaches in developing appropriate evaluation methodology for the kinds of exemplar programs discussed in Chapter 6. This discussion draws on the literature on evaluation generally, as well as the literature on evaluations of programs aimed at 0–8-year-old children (e.g., Bunston, Eyre, Carlsson, & Pringle, 2013; Flynn, 2011).

Additionally, the experience of the researchers at AIFS more broadly in conducting evaluations and developing evaluation frameworks across a range of areas informs this discussion. Other documents and reports that have informed this approach include:

- *Evaluation and Innovation in Family Support Services* (Child Family Community Australia [CFCA], 2013a);
- *Planning for Evaluation I: Basic principles* (CFCA, 2013b);
- *Planning for Evaluation II: Getting into detail* (CFCA, 2013c).

In broad terms, evaluations have four main elements. These are an initial conceptual element that involves identifying the objectives of the programs and developing an understanding of how the program aims to achieve these objectives. The second involves developing a series of evaluation questions to identify whether the program meets its objectives. The third entails identifying what information can be collected to answer the questions. The fourth entails implementing the data collection strategies. The fifth involves analysing the data and using them to answer the evaluation questions. These steps are discussed in more detail in the next sections.

9.2.1 Step 1: Identifying the aims of the program and the elements of the program designed to achieve them

Program objectives and the theory of change

Evaluation strategies need to be based on an understanding of the objectives of the program and how the activities undertaken as part of the program are intended to support the achievement of these objectives. One way of achieving this is through the development of a program logic (also known as results logic), which is a diagram showing the “underlying assumptions” of a planned program. A results logic illustrates why and how a program is presumed to work. Results logic diagrams are read from the bottom with the “inputs” or what is being done and follow the pathway and steps that will need to occur for the program to achieve its aims (Adamson et al., p. 10).

In the DFV prevention context, the process of developing program logic, and articulating the objectives of the program and how its activities support the achievement of these objectives, should be informed by the application of the socio-ecological theory of violence. The program should identify which of the four levels of influence (individual, close relationship, family and society) the program is intended to address. One or more of these may be the focus of the program. The program logic should also identify how the activities undertaken in the program are intended to support the achievement of the objectives by developing a “theory of change” that identifies how the activities being

undertaken in the program produce the outcomes to support the objectives. The theoretical position underlying the assumptions made about how the program will achieve its objectives should also be considered and made explicit in this context. In addition, features of the personal, organisational and social contexts that may militate against the program achieving its intended aims should be identified.

Program context

In the process of developing the program logic and identifying objectives, the context for the development and implementation of the DFV prevention program requires detailed consideration to identify how different factors involved in the four levels of influence impinge on the fulfilment of the aims of the project. This requires consideration of the organisational context in which the program is being implemented, the features and needs of the individuals and groups for whom the program is designed, and the needs the program activities are designed to address. It also requires consideration of the features of the environment in which the program is being implemented that may compromise the achievement of the program's objectives.

Principles and implications

- Program logic development should clearly identify the extent to which the program is intended to influence individual, community, institutional or cultural approaches to family violence.
- The program logic should identify how this impact is intended to occur.
- The program logic should clearly identify the important features of the organisational and social context in which it is being implemented that may support or impede achievement of the program objectives.

9.2.2 *Step 2: Formulating evaluation questions and evaluation design*

On the basis of the insights developed from identifying the program objectives, considering the program context, a series of questions need to be developed to guide the strategies for collecting information for the evaluation. These questions should be framed in a way that reflects the objectives in a measurable way. If it is important to understand particular aspects of the context in which the program is being implemented that may affect the achievement of the objectives, then the questions should also examine these issues.

The evaluation design should include strategies for measuring outcomes, to the extent possible in the context and within the resources available. The broad-level challenges in this context were discussed in the introduction to this section. Bearing these complexities in mind, there are two main strategies for measuring outcomes. The first is through the inclusion of a “control” or comparison group in the evaluation design. This is also known as experimental design and is considered the “gold standard” in evaluation design. The control group is a group that has similar features to the group that receives the program intervention but does not receive the intervention. In some circumstances, a “wait list” comparison group comprised of potential clients eligible to participate in a program that

has not yet been implemented can be used. Data are collected from both groups so that the differences between the groups can be measured. It can be difficult to identify control groups, particularly in small populations with distinct features. An alternative to experimental design is a strategy based on collecting data from the group that receives the program intervention before and after they have participated in the program (pre and post-test design). Comparison of data from these timeframes provides one means of assessing the impact of the program. In the context of prevention programs for 0–8 year olds, a pre and post-test design may be the most feasible.

A further potential strategy involves comparing data from program participants with existing population level data sources. The applicability of this method depends on the availability of appropriate population level data and comparability between these data and the evaluation data. One such source of data in relation to Australian children is the Longitudinal Study of Australian Children, which includes many detailed measures of child wellbeing and development. Some evaluations of programs for children have used data from the Longitudinal Study of Australian Children: see for example, Barnett, Fatoumata, & McEachran (2012). In some circumstances, this may be a valid method, particularly where larger groups are involved in the program being evaluated. Larger samples are more likely to support valid statistical comparisons with population level data.

An important consideration is the timeframe over which the evaluation is conducted. Many evaluations are conducted in parallel with the implementation of the program within a limited timeframe, for reasons of cost and convenience. This means the short-term impact of the program is examined in the evaluation but not whether these impacts are sustained over time or whether other impacts become evident over a longer timeframe. Given the long-term attitudinal focus of prevention initiatives, a longitudinal evaluation design could be considered in appropriate circumstances.

Understanding complexity

It is vital to consider the context in which data is collected and to acknowledge the complex social factors that influence perpetration of violence against women and children. The variety of factors, working at multiple levels of influence, may make evaluating the impact of prevention interventions difficult, particularly where those impacts are based on targeting different social factors. Ideally, the evaluation design phase would incorporate a consideration of the complexity of measuring social change and allow for the generation of contextualised information to support a broader understanding of the effectiveness of the intervention (Wall, 2013).

Principles and implications

- Specific and measurable evaluation questions need to be developed to guide the evaluation.
- For programs with a larger target group (such as those aimed at young women), experimental design, pre and post-test design and population level comparison may all be feasible approaches. Program implementation may be designed to allow for an experimental design to be applied by identifying demographically comparable contexts (high schools or universities, for example) and applying the program in one context but not the other to support an experimental design. From an ethical perspective, this

approach is justifiable in relation to pure prevention approaches but may be questionable in relation to programs that operate at the secondary or tertiary level. However, in circumstances where funding constraints lead to a limited or staged rollout, this may provide opportunities for a naturally occurring comparison group.

- For programs with a restricted and specialised target group, pre and post-test design approaches may be the most feasible. These approaches will depend on planning for the evaluation starting early and the pre-test data collections being applied at the outset.
- For larger programs requiring a more significant financial investment, a longitudinal design may be justified to assess whether program outcomes are sustained over time. Such a design, however, would need to take into account the extent to which changes in outcomes may be attributable to factors other than the program.
- When designing an evaluation, it is important to consider and acknowledge the complex social factors that influence how the effectiveness of prevention interventions can be measured.

Evaluation example 1: Evaluation of the LOVEBiTES and Respectful Relationships programs in a Sydney School

An Evaluation of the LOVEBiTES and Respectful Relationships programs in a Sydney School (2012) was conducted by Michael Flood and Vicki Kendrick from the University of Wollongong in partnership with the National Association for the Protection of Children from Abuse and Neglect (NAPCAN). The LOVEBiTES and Respectful Relationships programs are run by a number of services in schools across NSW and, since 2010, also in a number of other states and territories. The evaluation seeks to understand the impact of the LOVEBiTES and Respectful Relationships programs had when conducted, with Year 10 and Year 7 students respectively, at one particular Sydney school.

The evaluation applied a pre and post-test design. That is, students involved in each program were tested before and after participating in the program and each student's responses were matched and compared to assess whether their individual attitudes and self-reported skills changed over the course of the program. Although a follow-up element was initially planned, and the evaluation report notes this would have provided important additional insights about whether changes in skills and attitudes had persisted over time, this aspect of the analysis was abandoned due to difficulties with the data collection.

This evaluation is an example of an approach that conforms to a number of minimum standards of program evaluation, many of which are described in this chapter. In particular, it uses a model with three key elements: measuring the impacts of the program on social factors associated with effective violence prevention (e.g., knowledge, skills, attitudes and behaviours); using standardised measures to understand those impacts; and using a pre and post-program test design.

The evaluation also illustrates some of the challenges of school-based evaluations, particularly where data collection is attempted over a longer period of time.

9.2.3 Step 3: Identifying the information needed to answer the evaluation questions and collecting the information

This step involves identifying how to collect the information (data) that will enable the evaluation questions to be answered. There is a range of types and sources of data and the availability of these will depend on the nature of the program and context in which it is being implemented. Where multiple programs are being evaluated or a program is being

implemented in more than one location, a common “outcomes framework” and/or consistently agreed outcomes indicators and measurement tools can help integrate findings across programs and locations. A rigorous evaluation design will involve more than one, in some cases, several types of data being collected and analysed. In relation to programs for 0–8 years, the question of how data should be collected raises some complex issues. In this context, data collection can involve professionals, parents and the children themselves, depending on their age. Data on children may be collected indirectly or directly. Indirect methods are based on observation or collecting information from parents and carers about their observations of children, using standardised and validated measures (see e.g., Bunston et al., 2013). The measures applied should be closely tied to the theoretical basis of the program. There are many different measures of child wellbeing, development and social functioning available. Direct data collection from children, particularly in the younger age groups, requires very careful consideration, both ethically and in terms of what is feasible from a cognitive perspective. The following resources are useful in considering these issues:

- Sanson, A., Misson, S., Hawkins, M., and Bethelsen, D. (2010). The development and validation of Australian indices of child development part 1: Conceptualisation and development. *Child Indicators Research*, 3(3), 2010, 275–292.
- Sanson, A., Misson, S., Hawkins, M., and Bethelsen, D. (2010). The development and validation of Australian indices of child development part 2. *Child Indicators Research*, 3(3), 293–312.
- Barblett, L., and Maloney C. (2010). Complexities of assessing social and emotional competence and wellbeing in young children. *Australasian Journal of Early Childhood*, 35(2) 13–18.
- Moore, T., McArthur, M., & Noble-Carr, D. (2008). Taking little steps: Research with children—a case study. In Australian Research Alliance for Children and Youth (ARACY) & NSW Commissioner for Children and Young People (NSWCCYP) (Eds.). *Research with Children and Young People: A Compendium*. Sydney: ARACY & NSWCCYP. <telethonkids.org.au/media/54379/involvingchildrenandyoungpeopleinresearch_1_.pdf>.

The main types of data are now described.

Administrative data from the program/organisation covering issues such as: the number of clients who completed the program or to whom services were provided and information about referrals in or out of the program. Programs are often required to maintain these kinds of records for the purpose of reporting to funding bodies.

Quantitative data from surveys. These data support statistical assessment across a range of areas. These may include experiences (e.g., questions about whether the program worked for you), and attitudes (e.g., are particular kinds of attitudes more or less common after the program). Surveys involve information being collected in a format where the questions are carefully worded and participants are required to choose an answer from a pre-determined series of possible responses. Surveys may be administered by pen and paper, over the telephone or online. The decision about whether to use this approach, and in which format, should be based on the number of potential participants that may be surveyed and their levels of literacy and access to computers and telephones. The decisions

that need to be made in this area can be quite complex, but they may also be limited by the strategies available for practical or resource reasons. These kinds of data should be collected from staff and clients. Consideration should be given to including other stakeholders in data collection, such as referring agencies, as this can contribute valuable insight into how a program is operating.

Qualitative data is information based on in-depth interviews or focus groups with professionals associated with the program and clients. Unlike quantitative data, information collected in this way does not lend itself to statistical analysis and comparison. However, it allows rich information to emerge that can be very informative, particularly in understanding the perspectives and experiences of individuals and developing an understanding of how a program works. An interview format based on open-ended questions allows issues to be explored flexibly and deeply. Focus groups support a dynamic and interactive discussion that can be particularly useful for exploring practitioner perspectives. Caution should be used in applying focus groups for client data collection due to the possibility that sensitive material may be disclosed and confidentiality is not in the interviewer's control in a group setting.

Principles and implications

- Where multiple programs or sites are being evaluated, a common outcomes framework and agreed outcomes indicators will support the development of integrated findings.
- Administrative data sources should be sought for any evaluation. For new programs, program design and reporting requirements can be established to provide useful administrative data for evaluation and reporting purposes. Such data may include inward referral sources, outward referral patterns, client commencement and completion data, commencement and completion timeframes, and client demographic data.
- For most programs, optimum evaluation designs include quantitative and qualitative data sources, unless the target groups for programs are too small and too diverse to support quantitative approaches. Data sources should include staff, parents and children and may include other stakeholders. In some instances, where the reach of a program is intended to be widespread and attitudinal, such as school-based approaches, an evaluation based on quantitative data from the target audience may be a justifiable primary strategy supplemented by qualitative insights from program staff and clients.
- Data collection methods need to be carefully considered to accommodate differences in language, literacy and levels of cognitive development.
- Issues related to sensitivity and confidentiality should also inform choice of data collection methods. Focus groups may not be appropriate in some instances. Interviewers and interview approaches need to be carefully considered to support appropriate responses to sensitive issues. In some instances, the gender of the interviewer may need to be considered. Interviewers should be trained to be sensitive to the needs of the particular client group. This may include cultural sensitivity.

Ethical issues

Data collection can raise complex ethical issues, particularly where the program being evaluated deals with children and parents exposed to DVF. Data collections should

proceed in accordance with the principles outlined in the National Statement on Ethical Conduct in Human Research (2007), Updated March 2014, (NHMRC). In particular, the provisions in relation to informed consent, participant confidentiality and researcher obligations in relation to certain kinds of disclosures should be observed.

9.2.4 Step 4: Drawing conclusions from the information collected

The evaluation conclusions will be based on the findings that emerge from analysis of the data. Quantitative data is analysed to produce evidence based on statistics. Quantitative data may be analysed to produce descriptive or inferential statistics. Descriptive statistics “summarise, organise and simplify the data so that its basic features become clear and it is more easily managed and presented” (CFCA, 2013a). Such data support understanding of issues such as how many clients have used a program or service, what demographic characteristics they have and the timeframes in which services are delivered.

Some types of quantitative data may also be analysed to produce inferential statistics that examine more complex issues and associations than descriptive statistics. This type of analysis may be applied to survey data derived from a pre and post-test design, from experimental design or to measure differences among sub-groups of program users. Differences in the patterns in the data are then used to support conclusions that are drawn by inference on the basis of these patterns: for example, a shift in attitudes to gender equality may or may not be evident from pre and post-test design and this shift may be attributed to the impact of the program, in the absence of indications of other causes.

The analysis techniques applied to qualitative data are different from those applied to quantitative data. There are a variety of approaches but the approach most relevant to program evaluation is based on analysing interview and focus group data to understand the experiences of professionals and/or clients in the program. Such analysis might be focused on identifying themes that emerge from the data and the extent to which themes are similar or different for the individuals whose experiences are being examined. This kind of analysis supports a deeper understanding of personal views and experiences and the kinds of dynamics that influence them. They also may be used to support the interpretation of quantitative data or to examine the validity of inferential conclusions.

Evaluation example 2: Evaluation of Baby Makes 3 program

The *Respect, Responsibility and Equality: Baby Makes 3* (2011) program evaluation was conducted by David Flynn for VicHealth and Whitehorse Community Health Service Ltd. Baby Makes 3 is a primary prevention initiative for first-time parents run in partnership by Whitehorse Community Health Service and the City of Whitehorse Maternal Child Health Service. The evaluation framework was developed during the project planning stages and was intended to capture information to enable an assessment of both program process and program impact. The evaluation uses an “evaluation capacity building” model, which is an example of an empowerment model described earlier in this chapter.

The evaluation seeks to understand how well the program achieves the stated objectives: 1) increasing the capacity of first-time parents to build equal and respectful relationships in response to the changes following the birth of a child; and 2) increasing the capacity of health services and professionals to promote equal and respectful relationships during the transition to parenthood. A mixed method evaluation design was employed to measure the effectiveness of the program against these objectives, including the use of questionnaires, interviews and focus groups with program participants and program workers.

In line with the empowerment model, the evaluator in this case was engaged as a structured guide or coach in conducting the evaluation and individuals, groups and organisations involved in the evaluation were supported to learn about doing evaluations, by actually doing the evaluation.

This evaluation also provides an illustration of using a variety of data collection methods to support an analysis that contextualises the data and acknowledges that program impacts may be influenced by a variety of social factors.

10 Summary and implications

This chapter aims to support further policy and program development by setting out the main insights from this research based on a synthesised view of the evidence. Three overarching points inform this discussion. The first concerns the emergent state of knowledge and practice in the area of effective primary prevention, early intervention and response for children aged 0–8 years; as such, clear and definitive recommendations about models or programs to replicate are not possible. While the empirical evidence is very limited, the consultation process revealed a significant amount of practice knowledge and promising emerging programs that are as yet unevaluated, particularly in the area of school-based primary prevention for primary school children. The second concerns the extent to which practice approaches to primary prevention overlap with secondary and tertiary responses. Rigid distinctions are not necessarily sustained in practice and there is acknowledgement of a continuing need for complementary action at all three levels. Third, there is strong recognition of a need for a framework to guide further policy and program development in this area.

10.1 A coherent philosophy and integrated responses

This research has demonstrated that a range of approaches and understandings of primary prevention, early intervention and response for children aged 0–8 years exist among key stakeholders. Furthermore, theoretical distinctions are often not maintained in practice and it appears usual for there to be a wide overlap in the activities, services and programs undertaken, and ambiguity or uncertainty of the definitions of early intervention, primary prevention and response. In part this reflects the complexity of providing DFV prevention, early intervention and response, and it also evidences a need for a clear framework to guide understanding and practice.

A further issue that emerged strongly from the research, and has been highlighted in other analyses of DFV responses in NSW (e.g., Auditor General’s Report, 2011) and nationally (Australian Law Reform Commission, 2010) is the extent to which services of different types with varying client bases operate independently and in isolation from each other. The research suggests a significant need for better interconnections at several levels:

- between different types of services, including mainstream and specialised services;
- between family violence services and other systems, including the child protection system, the state-based justice system, family support systems, such as those that deliver maternal and child health services, and the education system.

The need for a more streamlined approach to service delivery is recognised in *It Stops Here*. In addition to a primary prevention policy framework, the insights from this research indicate a need for a mechanism to bring service providers, policy-makers and researchers with expertise in DFV prevention together to strengthen links and share knowledge. In Victoria, organisations such as VicHealth and Domestic Violence Victoria have played such a role, along with regional networks of service providers. Such leadership is now being driven at a national level by the Foundation to Prevent Violence Against Women and their Children. The groups involved in the governance structures set out in *It Stops Here* have the potential to make similar contributions in NSW. In particular, the DFV Reforms Delivery

Board and the focus on prevention in the Local Domestic and Family Violence Committees could fulfil the identified need. Services and individuals with expertise in relation to the groups considered in this report should be included in these groups.

The wider question of the extent to which the actions of NSW government departments in the DFV context align is also relevant, but was beyond the scope of this research. However, the Cross Government Committees that are part of the *It Stops Here* governance structure have the potential to support the development of a consistent approach to and understanding of DFV primary prevention in NSW.

Principles and implications

- The need for a framework to support a primary prevention approach has strong support in the literature and among stakeholders. The role of such a framework has several elements including articulating the nature and aims of primary prevention as a policy strategy in order to support shared understanding across agencies and among professionals and the community.
- The development of Specific Reference Groups under the *It Stops Here* framework provides an opportunity to establish a Specific Reference Group in relation to primary prevention. Such a reference group could support the development of a policy framework.

10.2 Funding structures and cycles

Fragmented and limited funding sources and structures have been identified in this research and other literature as factors that contribute to the ad hoc nature of DFV initiatives. This has several adverse implications. First, short-term funding cycles and small funding pools mean that programs are limited in scope and have little capacity for evaluation. Second, the need for programs to be community-driven, delivered in a context where community needs are well-understood and delivered in a way that means the service has the trust of the community results in longer lead time for the establishment of programs and the loss of community support if effective programs are unable to be maintained. Third, the disestablishment of services leads to the dissipation of professional capacity and expertise. Fourth, competition among services for limited grant and short-term grant funding undermines capacity for interagency collaboration.

We acknowledge that in an emergent area such as primary prevention of DFV in younger children, there is a balance involved in committing public funds to developing programs between responsible allocation of limited resources and creating the appropriate conditions for sound program development. This balance can be addressed through careful consideration of funding timeframes, reporting requirements and program evaluation requirements. It is notable that in the federal sphere, funding agreements for a range of family support programs delivered by the community sector, including in the Family Support Program (Department of Social Services and Attorney General's Department) have recently been moved to five-year cycles (in the absence of performance concerns) in response to concerns of the nature just outlined: (<http://kevinandrews.dss.gov.au/media-releases/89>).

Policy implications

- There is a clear need for funding agreements that support effective program implementation and are structured to take into account the full scope of program development and implementation activities, including the intensive establishment phase of DFV activities for some target groups and the need to develop trust within the client community.
- Program evaluations are critical for building the evidence base. It is important that funding agreements acknowledge the value of program evaluations and that separate or additional funding be available to build organisational evaluative capacity and to undertake evaluation activities.

10.3 Building on the evidence base

10.3.1 Primary prevention models

This research found that there is relatively little evidence for the efficacy of programs for children under 8 years. School-based primary prevention programs that address the underlying cause of DFV are endorsed in the literature and recommended through international and national policy frameworks. There are very few evaluated programs for children aged 8 years and under, however, as most evaluated programs are delivered to secondary school students. The limited evidence that is available is consistent with the views expressed during the stakeholder consultations conducted as part of this research. That is, it is important to deliver primary prevention programs to younger children, and it is important to retain a gendered analysis and understanding of DFV, and to work within a “whole-of-school approach” across the curriculum and in consultation with school communities.

The need for DVF prevention strategies aimed at children in the 0–8 age group is based on recognition of the need to implement such strategies early before behaviours and attitudes become fixed. However, these strategies are very much in their developmental phases and the existing literature is focused predominately on older children, adolescents and young people. There is a wide range of school-based programs delivered to Australian schools (mostly secondary schools) and an emerging number being delivered in primary schools, however not all meet the best practice recommendations for work in this area, with some based in a protective behaviours model or in anti-bullying models and lacking a gendered perspective. A key concern arising from our stakeholder consultations and the literature was the possibility that the gendered perspective may be being diluted in some school-based programs. Another clear concern raised in stakeholder consultations was that inconsistent and limited funding contributed to an inability of services to evaluate programs, and sometimes an inability of services to deliver programs past the pilot phase.

Policy implications

- There is a need for further evaluation of primary school-based primary prevention programs, particularly those for younger children. The available evidence suggests, however, that it is important that primary prevention programs target primary school age children.

- A primary prevention framework should articulate aims and approaches for these programs.
- School-based programs need clear policies and support in place for children who may already have been exposed to DFV.

10.3.2 Early intervention models

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

There was some evidence to suggest home visitation programs may be effective in reducing DFV, however many existing Australian programs generally don't aim to explicitly prevent or reduce DFV, but rather work at addressing associated risk factors such as isolation, disadvantage, parental mental ill-health, and substance abuse.

In general, early intervention models were understood as models that targeted populations of children or pregnant women/new parents at higher risk of experiencing DFV. We identified a small number of targeted school-based primary prevention programs aimed at populations of children perceived to be at risk of exposure and/or future perpetration, however evidence of efficacy of these programs is not yet clear. Programs for pregnant women and new mothers were also limited, though the literature indicates this is high-risk period for women.

Policy implications

- There is a need for clearer conceptualisation of what is meant by early intervention.
- There is a need for further development and evaluation of early intervention strategies for children and pregnant women at risk.
- There is a need for further programs for pregnant women and new parents.

10.3.3 Responses to children exposed or at risk of exposure to DFV

Recent statistics show that children are exposed to family violence to a significant extent in Australia. There is a considerable amount of international evidence showing that children experience significant negative impacts over the short and longer term from such exposure; however, our understanding of how this occurs and what factors mitigate against sustained adverse outcomes is developing. Despite this evidence, there is relatively little literature defining best practice responses to children exposed to DFV, and very few evaluated Australian programs.

Our service overview revealed that most programs and services for children were not distinct from programs and services for women, and there were many therapeutic programs for both mothers and children that aimed to address the mother–child relationship. However, stakeholders identified that current services were unable to meet the needs of the community in some areas, with long waiting lists and limitations sometimes put on access (e.g., some services will only see children where there are child protection orders in place).

While the literature emphasised the importance of addressing the intergenerational transmission of violence for children exposed to DFV, our stakeholders and interview participants were more predominately concerned with children’s immediate post-crisis needs. An element of best practice raised commonly by our stakeholder responses was for services to be child-centred, tailored to the child’s individual needs and family context, and working holistically with the child’s family, school and broader community.

Our service overview revealed several group programs for children in the 0–8 age group that addressed the inter-generational transmission of violence via psycho-educational content aimed at teaching children non-violent social norms, conflict resolutions skills and self-esteem. However, as with the primary prevention programs, very few are evaluated.

Stakeholders also agreed that allied health services, schools, and early childhood services may be ill equipped to respond to and identify children exposed to DFV.

Policy implications

- There is a need for further evaluation of response approaches to children.
- There is a need for further development of programs jointly addressing children and mothers’ needs.
- Further support is required for women’s DFV services and broader allied health and early education services to effectively respond to children exposed to DFV.
- Further support and development for child-centred therapeutic responses is required.

10.4 Final considerations

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

The findings of this research illustrate that there are very few prevention and early intervention activities that focus on young children. There are also significant gaps in the evidence regarding the effectiveness of prevention and early intervention activities aimed at the 0–8 age group. The evidence that is available suggests there is a strong rationale for supporting school-based primary prevention programs for younger children that address the underlying causes of DFV. Building this evidence base is crucial, however, if we are to address the impact of DFV on young children. There is also a critical need for a coherent policy framework that enables service providers, policy-makers and researchers to work collaboratively and effectively.

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Appendix 1: Service Map: Snapshot of services focusing on children aged 0-8 affected by DFV

New South Wales

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/early intervention/response
Breaking Free Program	Armidale and District Women's Centre	Community centre/Health service	Women and children -all	Breaking Free is a comprehensive group programme that is designed for women and their children who are escaping domestic violence.	Feminist, therapeutic	Group therapy aimed at empowering women and children leaving DFV situations. Also undertake community awareness, primary prevention activities	Response and primary prevention
Breaking the Silence in Schools	White Ribbon Foundation	Charity /NGO	Primary and Secondary School principles and senior teaching staff	Aims to educate/raise awareness and change attitudes by delivering workshops to school principles and senior teaching staff on gender and violence and information on how to promote respectful relationships in schools. Not directly delivered to children.	Behaviour/attitude change, primary Prevention, whole of school	Three day workshop delivered to primary and secondary schools	Prevention
Building Resilience in children project	Sutherland Family Services Centre	Not for Profit community organisation	Children and non-offending parent in the Sutherland shire area	Support and therapeutic pathways for families experiencing DFV. Promote and foster conditions for optimal development for children and young people affected by DFV. Uses evidence /research relating to effects of trauma /maltreatment on developing brains. The project was developed in 2010 in response to an identified lack of services for children affected by DFV in the area	Therapeutic, trauma-informed, holistic, mother/child bonding. Community education.	Provides counselling, group therapy, parenting programs that focus on parent/child relationship. Provides other support/advocacy services. Also engages with local services such as schools, MCHC, youth services and other professionals etc. to educate on effects of DFV, broaden understandings of trauma, brain and child development and the effects of trauma on children.	Response and prevention
Building Relationships	Wilmah Specialist Domestic Violence Service	Not for Profit community organisation	Mothers and children - all ages	To strengthen /repair bond between mother and child following DFV	Therapeutic – addresses the mother/child bond	Group activities include various arts and crafts, movement activities, sharing and story telling. Activities are also dependent on the need of the group and therefore can change depending on who is participating.	Response

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/early intervention/response
Children and Domestic Violence Support Group	Parramatta Community Health Centre and Family Court Counselling	Community Health Centre	Children aged 4-8 and 8-12 who have experienced DFV and where the mother has left the violent situation and where any court orders have been finalised	Nine-week therapeutic support group program for children aimed at helping children to understand their experience, strengthen bond with their mother, increase self-esteem and coping techniques.	Therapeutic, cognitive behavioural change	The nine-week sessions cover the definition of violence, the attribution of responsibility for violence, improving communication, problem solving and cognitive coping skills, the expression of feelings, including anger, increasing self-esteem, developing social support networks and the development of personal safety plans.	Response
Green Valley Domestic Violence Service		DFV service	Women and children	Aims to provide an integrated, coordinated model of response to DFV in the Green Valley area	Integrated crisis response	GVDVS is a partnership between NSW Health, the Department of Community Services, Police, Housing and a range of non-government agencies. Provides crisis response, case management and counselling.	Response
Karawee Karawee	Gunawirra Limited	Not for Profit community organisation	Aboriginal Torres Strait Islander children and their families	Enable Aboriginal children and their parents to learn different ways of managing anger and emotions	Therapeutic, cognitive behaviour change	Focuses on ways of expressing emotions and anger that are not harmful to the children and distressing for the parents who enact anger on their children. The program builds attachment and trust between children and their parents through regular art and sand play, through massage, through holding the child in their minds during times of great stress for the parents when they could easily act out.	Prevention, early intervention
Kool Kids Club	Weave youth and community services	NGO/Charity	Children aged 7-13 years	Educational outreach and prevention program for children aged 7-13 years living in La Perouse and surrounding areas.	Early intervention, social learning theory	Working with local schools the KKC provides free after school and holiday activity programs to support the development of resilience and life skills for children and young people from socially disadvantaged families, including children exposed to DFV- activities include: surfing, dance, short film projects, music workshops, sports, arts and cooking. 85% of children attending identify as Aboriginal	Early intervention, Primary prevention
Specialised children's counselling	St George Domestic Violence Service and	DFV and mental health service	Children		Holistic, therapeutic	Children referred to the mental health service are screened for DFV and then referred to the specialised counselling service. Ongoing case management, safety planning	Response

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/early intervention/response
	St George Mental Health Service						
Speak out for Kids	Kempsey Women's Refuge	Women's refuge	Children aged 8-12 who have been impacted by DFV.	Aims to address educate and respond to the issue of DFV within the Macleay Valley, NSW. Sub programs include public education and awareness campaigns as well as targeted response programs to children exposed to DFV- e.g. the Kids Can program	Community awareness, therapeutic	Kids Can Program: 8 week group work and art therapy program for 8-12 year olds impacted by DFV. Individual counselling and support for 8-12 year olds. Women Can: 8-week intensive program for women. Public awareness campaigns: education of local community on impacts of DFV on children	All
Staying Home Leaving Violence	NSW Dept. of Family and Community Services	State Government Dept.	Women aged over 18 years and their children, who have separated from a violent partner or family member and choose to remain in their own home, or in another home of their choice.	The Staying Home Leaving Violence program helps women and children escaping domestic violence to remain safely in their homes. Aims to prevent women and children becoming homeless following DFV		Staying Home Leaving Violence provides funding for 18 services across NSW. Caseworkers assist clients with their choice to separate from a violent partner and safely stay in their own home by conducting risk assessments, upgrading safety/security measures in homes, developing safety plans, working with police to remove offender, case work, advice and support.	Response
Sustaining NSW Families-SAFE Start	NSW Dept. of Health	State Government Dept.	Families with social and economic disadvantage	Coordinated, and integrated high-intensity health home visiting service that strengthens relationships between children, parents, and/or carers; builds parenting capacity; and enhances child development, wellbeing, and health in vulnerable families.	Early intervention, home visitation	Families offered intensive structured home visiting, ideally commencing in pregnancy and extending up until the child's second birthday. They are also provided with access to early intervention services through allied health services and psychosocial support. The Safe Start component works with vulnerable women during pregnancy - identified through routine antenatal screening. Safe Start provides comprehensive psychosocial assessment at least twice: at the first point of contact during pregnancy, and in the first 12 months after birth. Helps identify families with psychosocial difficulties (including depression and other mental health problems) during the	Early intervention

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
						critical perinatal and postnatal periods, and offers appropriate care and support.	
Respectful Relationships and Safe Families	YWCA NSW	Welfare organisation	Children, young people and their families	To work with children, young people and families in promoting healthy relationships and protective behaviours	Primary prevention		Primary Prevention
Women's and Children's Centre programs (various)	Weave youth and community services	NGO/Charity	Disadvantaged /vulnerable women, children and young people - priority to indigenous women and children	Aims to empower and enhance the lives of disadvantaged women and children through a variety of programs	Feminist, advocacy, cognitive behavioural therapy, mother child bonding	The Women's Centre offers a variety of services in relation DFV- Staying Home leaving Violence Program- assisting women and their children to leave abusive partners but remain in their own homes. Counselling, outreach, advocacy, therapeutic arts programs for children, mother and child activities,	Early intervention, Primary prevention and response

National

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Bursting the Bubble	Domestic Violence Resource Centre Victoria	NGO	Children, adolescents and young people	Inter-active website aims to help children and young people identify DFV, child abuse, sexual abuse, bullying, and get help	Community awareness, primary prevention,	Online tools, activities, information, interactive quizzes, fact sheets, videos and help services	Primary Prevention, early intervention
Children Ahead	The Alannah and Madeline Foundation	NGO, Charity	Children and their families who have experienced any DFV but also any type of violence, abuse, trauma	To provide children and their parents free relevant therapeutic support following experiences of violence or traumatic events	Therapeutic	Intensive counselling over many months up to 2 years. An ongoing relationship is fostered and maintained with children until they reach adulthood, so they have the necessary support to make a full recovery.	Response
Child Abuse Prevention Service		NGO, Charity	Families	To alleviate child abuse in all its forms		Keeping children safe 6 week support group for parents, 7 steps to safety group for families, protective behaviours program for children, Love Bites program for teens, playgroups, parent support groups, community education on family law and healthy relationships, national telephone helpline	Prevention & early intervention
Growing Respect	NAPCAN	NGO	Pre and Primary school children	To promote healthy and respectful relationships, promote non-violent social norms, and to challenge gender roles and stereotypes.	Primary prevention, whole of school, attitudinal change	Provides communities /schools with sustainable, localised, whole of community, respectful relationship programs and strategies aimed at preventing violence in all forms. The program encourages children to look at what it means to be a boy or a girl and how it influences relationships and behaviours, also encourages children to critically think about and "challenge the way they respond to community and societal attitudes and beliefs around gender-based violence" (Walsh and Peters 2011).	Primary Prevention
Safe from the Start Program	Salvation Army	Welfare organisation/ Charity	Children living in refuges and /or homeless services	Program developed in conjunction with Swinburne University. Aims to meet the therapeutic needs of children made homeless through DFV.	Therapeutic	Evidence-based resource pack for DFV and homeless service workers. It consists of various books, toys, ideas and tools to facilitate play therapy, for children in refuges or homeless shelters exposed to DFV.	Response
Love: Good , Bad and the Ugly (website)	Domestic Violence Resource Centre, Victoria	NGO, DFV Service	Older children and young people	Provides information on relationships, dating, sex and signs of unhealthy and /or abusive relationship behaviours		Articles, videos, fact sheets, case studies and interactive quizzes etc. Also help seeking section.	Primary prevention/early intervention

Australian Capital Territory

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Breaking the Cycle	YWCA of Canberra	Welfare Organisation/ Charity	Children aged 0–8, children and young people 8+ & parents who are homeless	Address the impact of homelessness on children. Specialised support to children within families experiencing homelessness and responding to issues such as trauma, domestic/family violence, mental health issues and substance abuse. Program goals were: mitigating the adverse effects of homelessness on children and preventing the intergenerational transfer of homelessness.		Developing individual support plans which include options for counselling, and referral of children and families to other community/health/educational support services. Visiting families in their homes to discuss children's needs, model positive interactions with children, support children's education and community connections. Providing parenting advice and education.	Response, early intervention
Child, Youth & Family Gateway (CYFG)	Barnardos (consortium with 3 other agencies)	Welfare Organisation/ Charity	All, including children, young people.	Provides information and referral services to vulnerable children, youth and families across the ACT.		CYFG provides a single place of contact for the ACT community and service system to gain information, receive initial support, complete an initial needs assessment, engage with a service and to promote the service system and build cross sector collaboration. Whilst it does not directly target DFV, it does deal with referrals that fall into this category. It does address other issues that may be present in these situations, as part of the holistic approach to meeting need and addressing risk.	Response
Newpin Program	Uniting Care Kippax	Welfare organisation/ Charity	CALD, young women, children 0-8	Newpin aims to break destructive cycles of family relationships by developing self-esteem in parents, building strong attachments between parents and children and imparting parenting and vocational skills to parents.	Addresses the intergenerational transmission of DFV	Educational activities: Increase parents' understanding of child development and effective child rearing, reduce parental stress by providing parents with opportunities to expand their social support networks, provide a therapeutic component to help parents understand their own childhood, reflect and break away from any hurt then develop or acquire a new insight	Response, Early intervention
Respect, Communicate, Choose	YWCA	Welfare organisation/ charity	Children in grade 5 and 6	Primary prevention of DFV and sexual abuse in primary schools through respectful relationship education and promotion and awareness of gender equality	Primary prevention, whole of school, attitudinal change	Delivered in the school setting for grade 5 and 6 children. Delivered by YWCA workers. Activities focus on understanding gender, sexism, homophobia	Primary Prevention

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Tuggeranong Child and Family Centre	Early Intervention and Prevention Services Community Services Directorate	Government dept./org	All (except GLBTIQ & rural & remote), & children 0-8	The key aim of TCFC is to provide a one-stop shop in the local community to assist parents.		TCFC provides the following early intervention services in partnership with other agencies: Case management, supported playgroups, young Mums group for mothers under 25 with their first child, parent child interaction therapy, counselling, MCHN,	Response, early intervention
Youth & Family Case Management Service	CatholicCare	Welfare Organisation/ Charity	All (except rural & remote), & children and young people, families			Medium to long-term case management provided through outreach. The Youth and Family Case management Service works with families, children and young people to provide a holistic, client driven, flexible model of assertive outreach support (for vulnerable and in need children/young people; with a particular focus on families with children/young people - pre-natal to 17 years).	Response, early intervention

Victoria

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Baby Makes 3 program (VicHealth)	Whitehorse Maternal Child Health Centre, Warrnambool Maternal Child Health Centre	Community Health Centre/Local government	Infants, new parents	Provides Respectful Relationships sessions for new parents	Primary prevention, attitudinal change, community education	Three week discussion-based program. Sessions cover; maintaining healthy relationships in transition to parenthood, exploration of gender norms around parenting, different parental roles and expectations and impacts on parents	Primary Prevention
Berry Street Victoria Family violence service		NGO/Charity	Children, women	The DFV service aims to provide a fully integrated, holistic, culturally appropriate service to women and children who have experienced violence	Holistic, therapeutic,	Berry street assists women and children in ways that facilitate self-determination. Services for children include, group therapy, foster care, residential care, mother and child therapy. Also some early intervention programs such as the Reaching more Kids' program in Gippsland and the Communities for Children program in Broadmeadows	Response and early intervention - however also partake in some prevention activities such as community education.
Bright Futures	Merri Outreach Support Services	Homeless Service	Children who are experiencing homelessness and DFV.	Bright Futures provides enhanced case management and/or group work responses to children whose families are accessing Homelessness and/or Family Violence Services in the North West Metropolitan Region of Melbourne.		Bright Futures offers 3 streams of support to children and young people -assessment and case planning, enhanced case management, group work/therapy. Group work focuses on increasing positive peer relationships, building confidence and self-esteem, reducing isolation. Child centred.	Response, early intervention
Children's counselling	Women's Health West	Community Women's Health Service and Refuge	Children and teenagers who have experienced DFV	Specialist children's counsellor available	Therapeutic	Music and art therapy	Response
Children's services	Elizabeth Hoffman House	Refuge and DFV service	Aboriginal children	To provide a range of services to Aboriginal women and children experiencing DFV in the Melbourne metro area	Feminist	Outreach, counselling, court support, group therapy, housing assistance, refuge, playgroups. Also run specific prevention. Early intervention programs.	Response

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
Children's Therapeutic Program	Emerge Women and Children's Support Network	NGO, Charity	Children (age not specified)			Led by an art therapist, this early intervention program encourages traumatised children to explore themes including safety, bullying, violence and self-empowerment through a variety of art media. The program is accessible - options for therapy to occur are flexible i.e. therapists can go to schools or home if safe.	Early intervention and response
Changing Family Futures	Child Protection and Victoria Police	Govt. Dept.	Children in child protection as a result of DFV	To strengthen safety and stability, improve outcomes for children and families who are engaged with Child Protection as a result of DFV and reduce the number of re-reports and improves outcomes for children exposed to DFV.	Child Protection?	Work with other services and agencies to coordinate responses to DFV, early identification of DFV, improve access and take-up of support services in the area including DFV services, counselling, family therapy, case management, coordinate information gathering and data with other services in Gippsland.	Early intervention and response
Child First	Department of Human Services, Victoria	Government Department, child protection	Vulnerable/ at risk children	To ensure children and families experiencing DFV, abuse, neglect are linked to appropriate services.	Child Protection	24 Child First contacts across the state. Each Child FIRST provides a central referral point to a range of community-based family services and other supports within each of the Child FIRST catchment areas.	Response, early intervention
DFV integrated service	Merri Community Health Service	Community Health Service	Women and children			Support, counselling, advocacy, safety planning, needs assessments	Response
Families at Home project	Kildonan and Crossroads	Welfare organisation/ charity	Families experiencing violence or at risk or violence	To provide an integrated coordinated response to prevent and respond to DFV and subsequent homelessness in at risk families in the Whittlesea area	Integrated holistic model	Specialist women and children's DFV workers, financial aid workers, and men's behaviour change worker	Early intervention and response

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
Family, Youth & Children's Services Unit	Gippsland Lakes Community Health	Health service	Families	Integrated model of care for perpetrators, victims and children experiencing family violence that works closely with the Maternal and Child Health (MCH) Service to provide appropriate support when Family Violence has been identified by the MCH program. The model is multidisciplinary, crosses all programs in the unit and applies strong service coordination and case management principles from initial entry through to exit from services.		The FYCS Unit consists of the following programs; • Child FIRST • Integrated Family Services • Alcohol & Drug • Family Violence Outreach • Men's Behaviour Change Program • Family Violence Women's and Children's Counselling • Generalist Counselling • Homelessness Support Program • Creating Connections – youth homelessness support • Youth Justice • Reconnect • School Focused Youth Services • Maternal and Child Health including Enhanced Home Visiting • School Nursing • Youth, Pregnant and Parenting group • Disability Services including Early Childhood Intervention	Early intervention and response
Feeling Cool & Tuesday Club Groups	Reach Out for Kids	Charity	Primary school children who may or may not have experienced DFV	To assist children with resilience and coping skills	Social learning theory, therapeutic	Weekly after school sessions. Also family and children's counselling offered	Early intervention and response
Filling the Gap Service Model	Good Sheppard, Victorian Integrated Family Violence Service System	Homeless Service	Women and children who have experienced DFV in the last 12 months	Integrated post-crisis support service to prevent homelessness following DFV	Holistic /integrated	Identifies women and children who are vulnerable to becoming homeless. Case management and financial assistance	Response
Keeping Boorais Safe	Elizabeth Hoffman House	Refuge and DFV service	Young Aboriginal mothers and their children	To prevent violence, neglect, maltreatment. To promote positive parenting practices		Engage young Aboriginal mothers in a 10-week parenting program that delivers a series of education workshops around rights and responsibilities and support around family violence and health related issues. Facilitates a playgroup for Aboriginal Mothers and their children	Primary Prevention Early Intervention
Living in Harmony Kidz Biz Program	North Yarra Community Health	Health Service	Primary school aged children in Richmond housing estates	Aiming to build lasting change in attitudes towards respectful relationships amongst primary school aged children in the Richmond housing estates	Primary prevention, attitudinal change	No info available	Primary Prevention

Project/program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/program logic	Service/program activities	Prevention/ early intervention/ response
North West Regional Children's Resource Program	Merri Outreach Support Services	Homeless Service - SAAPS	Children who are experiencing homelessness and DFV.	The North West Regional Children's Resource Program assist the homelessness sector in identifying and addressing the specific needs of children experiencing homelessness and family violence.		A range of support to homelessness services in the North and West Metropolitan Region who work with children in homeless families. The program is state-wide with co-coordinators in each metropolitan region and in rural regions as well.	Response
Maternal & Child Health Nurse services	Maternal and child health services	Local government	Mothers and infants, pre-school children	Health and developmental screening of all children, primary health care, supporting well being of families, increasing focus on vulnerable families		Universal screening for all mothers at the 4 week key age and stage assessment, a health and well being assessment asking questions about physical and mental health and screening questions for family violence. Appropriate referrals made to either DV workers, child protection, police, dependant on level of risk to children and the situation	Early intervention
PARKAS (no longer in operation)	Royal Children's Hospital Mental Health Service	Health/mental health Service	Children aged 8-12 and their mothers	Aims to provide a safe space for children and their parents to discuss and acknowledge the violence and trauma they have experienced.	Psycho-therapeutic	Group therapy for children and mothers are run in parallel, eventually both groups join. There is a focus on providing children the opportunity to reconnect emotionally with mothers.	Response
Peek-a-boo club and Refuge for babies in crisis (no longer in operation)	Royal Children's Hospital Mental Health Service	Health/mental health service	Infants 0-4 years and their mothers/caregivers who have been exposed to 'significant levels' of DFV.	Aims to restore and repair the infant/mother bond following trauma, DFV, abuse. Refuge provides therapeutic support and residential care to infants following trauma, DFV etc.	Mother child bond, attachment theory, therapeutic	Play therapy sessions, group therapy, art therapy delivered by clinicians at the RCH Integrated Mental Health Program.	Response
Programs for mothers and children	Eastern Domestic Violence Service	DFV service	Mothers and their children (age not specified)		Therapeutic	Specialist counselling for mothers and children, playgroups, group therapy	Response
Promoting safe and respectful relationships school program	Barwon South West Integrated Family Violence, Bethany	DFV service, welfare organisation	School children, teachers, welfare workers.	To build the capacity of schools in the Barwon South West to undertake gender-based violence prevention activities. To support schools to recognise and respond appropriately to children and young people experiencing family violence.		Coordinates DFV prevention strategies across the Barwon south west region- including primary school-based healthy relationships education, facilitating training and personal development opportunities for teachers, welfare/community workers. Also created a 'Champions' tool kit for educators.	Primary Prevention

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/program aims	Service/ program logic	Service/program activities	Prevention/ early intervention/ response
Sexuality Education & Community Support (SECS) program	Barwon Health	Community Health Service	Prep-12 school students	Whole school (P-12 & community) engagement in sexuality education – inclusive of gender equity and respectful relationships.	Primary prevention, whole of school	Sexuality education model that relies on community participation. Covers gender, power, equality, respectful relationships- not directly violence	Primary Prevention
Solving the Jigsaw	Centre for Non Violence	Not for Profit community organisation	Primary school and lower secondary school children	Solving the Jigsaw is a school-based primary prevention program focusing on gendered violence, bullying and DFV. The program aims to create a culture of well-being and resilience in schools.	Primary prevention but targets communities at risk, social learning theory	40 weekly sessions in primary schools and lower secondary levels for at risk: delivered to at risk & whole class. Training courses for teachers, welfare workers and parents so that they may deliver the program. Program teaches empathy, respectful relationships, self-esteem, values, communication, problem solving and conflict resolution, as well as education about different forms of violence, and power. Encourages students and teachers to be committed to challenge violence in all its forms.	Primary Prevention
Way of the Warrior and Wushu	Merri Outreach and North West Regional Children's Resource Program	DFV service, Community NFP org	Aboriginal children aged 8-12 who have experienced DFV, homelessness	To provide Martial Arts Therapy Aboriginal children who have experienced DFV and homelessness	Social learning theory, therapeutic	Peer educators and trained instructors deliver the program over 8 weeks. Children learn to identify feelings, deal with emotions appropriately, feel connected to peers and community, manage anger, improve self-esteem and confidence, increase safety awareness, and learn basic self-defence.	Early intervention and response

Tasmania

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
Focus on Family Support	Youth, Family and Community Connections	Community Organisation	Children and young people	Early intervention, easy access to gov and non gov services strengthen integration and coordination between services		Case management and outreach services Flexible early intervention to families in need. Co-located child protection workers available to workers and families	Early intervention, response
Respectful Relationship Education	Youth and Family Services YAFS	Community Organisation	School children grades 2-6 and years 7-9.	To promote healthy, respectful and safe relationships, explore the concept and use of respect, encourage positive communication and assist students to develop self-care and rapport with peers, adults, the school and wider community.	Primary prevention, attitudinal change, gendered, whole of school.		
Centrecare Kids Club	Centrecare	Welfare Organisation	Children and non-offending parent	TO provide a safe environment for children to acknowledge, discuss and heal from their experiences of DFV		Intensive group programme that consists of two parts: an after school session for the children followed by a session for the non-abusive parent the next day. In the group the children have the opportunity to talk about and process their experiences and are helped to find ways to deal with the accompanying emotions including through play, art and other activities	Response

Queensland

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
ACT for Kids	ACT for Kids	NGO, Charity	Children	Aims to prevent child abuse and neglect through various programs		Early intervention for families at risk through the Family Support Service, intensive counselling service and support for children who have experienced violence, abuse, maltreatment, neglect, community education/awareness activities	Early intervention, response and Primary Prevention
Bay Safety Mates	Bay Safety Mates	Community Organisation	Primary school children who have experienced DFV	Program developed for schools and community orgs to be delivered to children. The program aims to provide a safe and friendly environment where issues of domestic violence are explored using different mediums.			Response, early intervention
Community awareness program, Children's Counselling Program, Safety at Home Program	Caboolture Domestic Violence Centre and Centre against Violence	DFV service	Primary school children, parents, teachers, school community	To provide counselling to children affected by DF, To educate and raise awareness in local community and schools. Safety at Home Program aims to assist children and their non-offending parents to remain in the family home following DFV.	Holistic	In addition to DFV counselling, the service delivers respectful relationship education at local schools and community groups/locales	Response, early intervention, Primary Prevention
Children's Intervention Service	Yoorana Women's Domestic Violence Resource Centre	DFV service	Children	Support and counselling program for children who have experience DFV. Early intervention service in local schools		Counselling, also delivers primary prevention programs in schools- Love Bites and Bay Safety Mates (see below).	Early intervention, response and Primary Prevention
Evolve Therapeutic Service	Queensland Health	Health service, government dept./org	Children aged 0-8, and children and young people 8+	Provide therapeutic services to children and young people 0-17yo who are affected by trauma, neglect or other forms of abuse (including witnessing domestic violence or other affects of domestic violence).	Trauma- informed	Service model involve utilising a systems approach to work with wide range of people involved with young person's life. Assessment includes close consideration of impacts of trauma as well as areas such as brain development and attachment impacts of the children's histories.	Response

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
KIPP (Kids Intervention Prevention Program)	Wide Bay Women's Health Centre	Community Women's Health Service, DFV crisis service	Children aged 0-8	To provide a culturally appropriate sexual abuse, violence, incest support service for children	Therapeutic		Response
Koora the Kangaroo		Whole of school, anti-bullying, social learning theory	Queensland DFV Resource Centre	QLD	Provide a culturally appropriate violence prevention and cultural education program aimed at addressing the high rates of violence, dysfunction, lack of respect for culture and Aboriginal elders at Woorabinda State School.	Yes, Bradford & Nancarrow, 2005	
SUPA Kids Program	Domestic Violence Prevention Centre	NGO	Primary school children prep-6	Class room based education to raise explore safety, understanding of self and others, positive and respectful relationships, angry feelings	Whole of school		Prevention
What's the Buzz Bumblebees	Phoenix House	DFV and mental health service	Preschool aged children who have experienced DFV, child abuse or neglect		Therapeutic	A therapeutic pre school operates for two half mornings a week providing a comprehensive assessment and referral programme for young children and families, and therapeutic interventions as required.	Response, early intervention

South Australia

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
Kids 'n' You Family Services	Women's and Children's Health Network SA	State Government service	Women and children		Holistic, therapeutic	Centre-based services for women with children 0–3 years who have experienced the effects of domestic violence, mental health problems and childhood abuse – including one to one support, linking and referral to other services, advocacy and group support programs offered during school terms, intensive home visiting, and group work for families	Response, early intervention
Together4kids Therapeutic Children's service - homeless	Relationships Australia SA	NGO	Children and service providers.	To up skill the DV and homelessness sector to become child focussed. Provide therapeutic group programs for children		One on one and group therapy sessions. Also delivers sector capacity building supporting the DV and homelessness services to be child focussed through a range of skills and knowledge based professional development training	Prevention (through sector capacity building), response
Respect, Communicate, Choose	YWCA South Australia	Welfare organisation/charity	Children in grade 5 and 6	Primary prevention of DFV and sexual abuse in primary schools through respectful relationship education and promotion and awareness of gender equality	Primary prevention, whole of school, attitudinal change	Delivered in the school setting for grade 5 and 6 children. Delivered by YWCA workers. Activities focus on understanding gender, sexism, homophobia	Primary Prevention

Western Australia & Northern Territory

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
Children of Domestic Violence	Waratah Support Centre	Health service	Children and adolescents	Specialised counselling to children and adolescents who have experienced domestic violence and or sexual abuse.	Therapeutic, Holistic	Kids and Teens Waratah places great value on supporting the whole family through the healing process. Counsellors can provide advocacy as well as information and referral to other community organisations where appropriate.	Response
Children's counselling	Yorgum Aboriginal Counselling Service	Health service	Aboriginal children			Provides counselling, support and referral with a range of concerns including family & personal relationships, trauma, sexual abuse, family or domestic violence, grief & loss, self-harm, suicide, cultural-identity difficulties and the effects of historical & current racism.	Response
FVPLS (Family Violence Prevention Legal Service).		NGO	Aboriginal families		Advocacy	Provides early intervention and prevention services for Aboriginal & Torres Strait Islander women, men, children and young people affected by domestic violence.	Prevention, early intervention, response
Family violence advocacy	Anglicare	Welfare Organisation/ Charity	Families			Provides counselling, short-term support, safety planning and goal-directed intervention for children, young people, men and women who have been exposed to or involved in domestic violence.	Response
Family violence counselling	Chrysalis Support Services	Health service	Children and general			Provides counselling for male & female adults, young people and children who are experiencing trauma as a result of recent or past sexual abuse or domestic violence.	
Patricia Giles Children's Counselling Service (CCS)		Health service	Children			Counselling and group therapy for children who have experienced DFV	
Pilbara Community Legal Service		Legal service	Women and children			The service assists families and individuals at risk and provides crisis support for women and children experiencing domestic violence, following removal of the perpetrator.	

Project/ program	Host organisation	Nature of host organisation	Target population &/or setting	Service/ program aims	Service/ program logic	Service/ program activities	Prevention/ early intervention/ response
We Hurt Each Other, We Hurt Our Kids. Family Violence Prevention Program	South West Aboriginal Medical Service (SWAMS),	Health service	Aboriginal families	DFV prevention for indigenous people including support, information & referral for women and children escaping family or domestic violence; strengthen social norms against violence; and improve the coordination of support services available to aid children & adults recovering from family violence			Early intervention and Response

Appendix 2: Roundtable participants

A. Sydney Roundtable Consultation Attendees

National

Human Rights and Equal Opportunity Commission – Children’s Commissioner

Human Rights and Equal Opportunity Commission

Women with Disabilities Australia

ACT

YWCA Canberra

NSW

Insideout Disability

National Centre of Excellence to Reduce Violence Against Women and Their Children now known as Australia’s National Research Organisation for Women’s Safety (ANROWS)

NSW Health Child and Family

Redfern Legal Service

Staying Home Leaving Violence

St George Migrant Resource Centre

WDVCAS – Blue Mountains

Women’s Health New South Wales

YWCA NSW

B. Melbourne Roundtable Consultation Attendees

VIC

Aboriginal Family Violence Prevention and Legal Service

Dr Catherine Barrett, La Trobe University

Bright Futures, Merri Outreach Support Service

Wendy Bunston, Latrobe University

Dr Julia Coffey, Youth Research Centre, The University of Melbourne

Commission for Children and Young People Vic

David Smyth, Violence Free Families

Debbie Ollis, Deakin University

Lucy Healy and Kirsten Diemer, The University of Melbourne

Safe from the Start Program, Salvation Army

Women's Health West

Partners in Prevention

C. Brisbane Roundtable Consultation Attendees

National

Association of Women Educators

NAPCAN

Women's Legal Service

QLD

ACT for kids

Department of Communities, QLD

Ipswich Women's Centre Against Domestic Violence

Talera BCS

D. Phone Consultations /interviews

NSW

Domestic Violence NSW (DV NSW)

Education Centre Against Violence, Sydney West Area Health Service

ACON

Far West Community Legal Service

VIC

Berry Street

InTouch Multicultural Centre Against Violence

QLD

Phoenix House

Appendix 3: Request for information



Australian Government

Australian Institute of Family Studies

DOMESTIC AND FAMILY VIOLENCE PREVENTION REVIEW AND EVALUATION: REQUEST FOR INFORMATION

ABOUT THIS RESEARCH

The Australian Institute of Family Studies is conducting two related research projects, commissioned by Women NSW, on domestic and family violence services. The projects focus on two types of services:

- prevention and early intervention services focusing on at risk groups and communities; and
- prevention, early intervention and response services focusing on young children affected by domestic and family violence.

A third project – focusing on prevention programs targeted at men and boys - is being conducted by the University of Western Sydney.

This research has been commissioned and funded by Women NSW.

Project 1

The first AIFS project examines prevention and early intervention services that target groups and communities known to be at higher risk of experiencing domestic and family violence, or who face barriers in accessing existing services. These groups include: Aboriginal and Torres Strait Islander women; women with disabilities; women in culturally and linguistically diverse communities; people who are same-sex attracted, intersex, sex or gender diverse; younger women; older women; and women in remote communities.

Project 2

The second AIFS project examines prevention, early intervention and response services that target children aged between 0-8. In addition to examining prevention approaches for this age group, the research aims to identify what services children who are affected by domestic and family violence need, what is being done to support them, what models of service delivery are most effective, and what are the gaps in services.

Working closely with key stakeholders, these projects will examine:

- the role domestic and family violence services play in addressing the needs of at-risk groups and/or children, and the effectiveness of services in addressing those needs;
- the characteristics of good practices and exemplar models in targeting at-risk groups and communities and/or children;
- strategies to build on existing good practice.

This research will contribute to the implementation of the National Plan to Reduce Violence against Women and their Children by expanding the evidence base on prevention initiatives. It will also inform funding decisions by Women NSW by setting out recommendations for enhanced or new approaches and exemplar projects/models to support implementation in NSW.

ABOUT THIS REQUEST FOR INFORMATION

To assist AIFS in developing a comprehensive understanding of current domestic and family violence practice across a range of services, we are seeking information from service providers and program managers.

For the purpose of this information request, we are taking a broad approach to how we define the various types of domestic and family violence interventions. That is, we are interested in hearing about services and programs that focus only on primary prevention activities, and also from services and programs that undertake work that could be characterised as primary prevention within the context of delivering other services. For further discussion of DFV primary prevention we refer you to Women NSW's discussion paper 'Preventing Domestic and Family Violence'.

If your service offers more than one relevant program, please complete one survey for each program.

YOUR PRIVACY

The participation of individuals in this research is confidential and we will not ask for the name/s of individual practitioners in this information request. However, the information provided in response to this information request **will be** attributed to particular programs or services in reports or publications that arise from this research.

INSTRUCTIONS

This information request will take an average of 30 minutes to complete.

For some questions, you need to select the option or options that correspond to your answer. In most instances, you are asked to type in an answer.

If at any stage you want to take a break from the survey and finish it later, press the Resume later button.

You will be asked to enter and save a name, password and email address for the survey.

After saving these details, you can simply close the window containing the survey.

Do not press the 'Exit and clear survey' button unless you want to delete your answers permanently.

To come back to where you left off after saving your answers:

- use the link that will be emailed to you, or
- press the load unfinished survey button on the first page of the survey and enter the name and password you provided.

QUESTIONS

1. Please provide the name of the service or program that is the subject of this response.

Please write your response here:

2. If applicable, what is the name of the host organisation through which the service or program is delivered?

Please write your response here:

3. What is the nature of the host organisation?

Please choose all that apply:

- Non-government organisation or charity
- Health service
- Community-based organisation
- Legal service
- Commonwealth government department/organisation
- State/Territory government department/organisation
- Local government organisation
- Other: _____

4. In which state or territory is the service or program located?

Please choose all that apply:

- Australian Capital Territory
- New South Wales

- Northern Territory
- Queensland
- South Australia
- Tasmania
- Victoria
- Western Australia
- National

5. What location does your service or program operate in?

Please choose all that apply:

- Metropolitan
- Regional
- Rural
- Remote

6. What is the target group for this service or program?

Please choose all that apply:

- Aboriginal or Torres Strait Islander women
- Women from culturally and linguistically diverse (CALD) communities

Please specify focus community, if any: _____

- Women with disabilities
- GLBTIQ persons

Please specify focus community, if any: _____

- Women with mental ill-health
- Young women
- Older women
- Women from rural or remote communities
- Infants and children aged 0-8 years
- Children and young people aged 8+ years
- General
- Other: _____

7. Does your client base generally reflect this target group?

Please choose only one of the following:

- Yes
- No

8. If no, please indicate the demographic characteristics that would apply to the majority of your clients.

Please choose all that apply:

- Male
- Female
- Women from culturally and linguistically diverse (CALD) communities

Please specify focus community, if any: _____

- Aboriginal or Torres Strait Islander women
- GLBTIQ persons

Please specify focus community, if any: _____

- Women with mental ill-health
- Young women
- Older women
- Women with a disability
- Women from regional, rural and remote communities
- Infants and children aged 0-8 years
- Children and young people aged 8+ years
- General
- Other: _____

9. Did the program or service keep records about the number of clients who were referred to/accessed the service or program for the 2012-13 period?

Please choose only one of the following:

- Yes, please specify: _____
- No

10. What is the funding arrangement for the service or program?

Please write your response here:

11. How long has the service or program been running?

Please write your response here:

12. What are the primary aims of the service or program?

Please write your response here:

13. Does the program or service undertake any work that could be characterised as primary prevention?

Please choose only one of the following:

- Yes
 No

14. If yes, please describe the primary prevention work the service undertakes. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

15. Does the program or service undertake any work that could be characterised as early intervention? Please choose only one of the following:

- Yes
 No

16. If yes, please describe the early intervention work the service undertakes. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

17. How are clients usually referred to the service or program?

Please write your response here:

18. Have clients usually already been screened for DFV indicators prior to being referred to/accessing the service or program?

Please choose only one of the following:

- Yes
 No

19. If clients have already been screened for DFV prior to being referred to the service or program, please describe how this information is shared between services.

Please write your response here:

20. If clients have not already been screened for DFV prior to being referred to/accessing the service or program, does the service or program have a protocol/process for screening for DFV?

Please choose only one of the following:

- Yes
- No

21. If the service or program does screen for DFV, please describe how the service or program undertakes this screening.

Please write your response here:

22. Does the service or program have a protocol for conducting risk assessments?

Please choose only one of the following:

- Yes
- No

23. If yes, please describe the process for conducting a risk assessment.

Please write your response here:

24. Please describe what happens when an assessment indicates a presence of risk.

Please write your response here:

25. Have there been any internal or external evaluations conducted of the service or program?

Please choose only one of the following:

- Yes
- No

26. If yes, please provide details of the evaluation. You may upload documents below.

Please write your response here:

Please upload between 0 and 4 files.

27. Which of the following best describe the model or framework underpinning the service or program.

Please choose all that apply:

- Therapeutic
- Cognitive behavioral therapy
- Feminist
- Community engagement

- Community education
- Early childhood education
- Primary school education
- Secondary school education
- Crisis support and intervention
- Advocacy
- Human rights framework
- Whole of community approach
- Parenting skills and education
- Child development
- Mother/child attachment
- Community awareness-raising
- Holistic/multi-component response
- Public health model
- Community capacity building
- Child focused/centred
- Protective behaviours
- Relationship skills
- Other: _____

28. What are the three most important characteristics of effective practice in your program type?

Please write your response here:

29. What are the three main challenges or barriers to effective practice in your program type?

Please write your response here:

Concluding comments

30. Are there services your client base needs but your program is currently unable to provide?

Please choose only one of the following:

- Yes
- No

31. If yes, please provide details:

Please write your response here:

32. Is there anything further you wish to add regarding the service or program?

Please write your response here:

Thank you for taking the time to complete this request for information