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beyond zero tolerance: key issues and future directions for family violence work in new zealand

A REPORT FOR THE FAMILIES COMMISSION

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Our specific functions under the Families Commission Act 2003 are to:

- > encourage and facilitate informed debate about families
- > increase public awareness and promote better understanding of matters affecting families
- > encourage and facilitate the development and provision of government policies that promote and serve the interests of families
- > consider any matter relating to the interests of families referred to us by any Minister of the Crown
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- > consult with, or refer matters to, other official bodies or statutory agencies.

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This report is dedicated to Dr Linda Ellen Saltzman, friend and colleague.

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beyond zero tolerance: key issues and future directions for family violence work in new zealand

A REPORT FOR THE FAMILIES COMMISSION

JANET FANSLow

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1. INTRODUCTION

Family violence is currently receiving an unprecedented level of attention within New Zealand. In 2005 both a Ministerial Team on Family Violence and a Taskforce for Action on Violence Within Families have been established, an Open Hearing into the prevention of Violence Against Women and Children has been held, and a workshop on family violence involving ministers, public officials, non-government organisations and others has been conducted. Family violence has been identified as one of five government priorities (Ministry of Social Development 2004a). New Zealand's responsibility toward reducing violence has been recognised in terms of the international human rights framework, the international policy framework and the New Zealand legislative and policy framework (New Zealand Parliamentarians' Group on Population and Development 2005). These efforts represent the latest wave of a long history of activism around violence, raised initially through the women's movement, but now recognised as a global health problem (Krug, Dahlberg, Mercy, Zwi and Lozano 2002), and a fundamental threat to human rights (UNIFEM 2003; UNICEF 2004).

While progress has been made in recognising the importance of this issue, and in terms of gaining clearer ideas of the scope and consequences of family violence, there is still much that remains to be learned about ways of responding to violence and ultimately preventing it. This recognition of the scope and consequences is important, however, because this knowledge gives us the licence to move beyond merely reacting to violence with concern and distress. The understanding we have gained signals strongly that if we are to address this serious problem in a serious way, we need to begin to think strategically about how to change things.

This report has been commissioned to set the scene for future work in the family violence prevention area by providing an overview of New Zealand's responses to family violence and trends in both government and community initiatives. It provides an overview of:

- > definitions of family violence
- > the level and nature of family violence in New Zealand
- > the effects of family violence on individuals and the community
- > information on interventions.

This report is not intended to provide a comprehensive review of all activities and interventions related to family violence. Its purpose is to provide an overview of some of the key issues in the field, and present a framework for assisting future conceptualisations and activity. To do this, of necessity, it presents a 'broad brush' outline of some of the initiatives that have been attempted. To present this information in brief always carries risks. Readers looking at each seemingly small piece of information need to be aware that there is usually a vast field of theoretical and conceptual work, as well as complex methodological subtleties (not to mention ideological positions), underlying each area. Definitions, for example, while the most basic building block of any field, are an area fraught with complexity, with active debate raging about almost every aspect from age ranges, to types of relationships included, to types of violence that should be counted. Similarly, interventions are never straightforward – even those few that come with sound theoretical bases, evidence of programme fidelity, and supported by evidence from strong evaluation designs are limited by issues such as 'with whom do they work, under what conditions, and for how long?' Given the youth and complexity of this field, and the relatively few research resources that have been invested, sometimes the best we can do is identify the issues that need resolution and attempt to fill the gaps.

What is clear is that family violence affects a significant number of people, with potentially profound implications on their health and wellbeing, and on the functioning of wider society. While we don't know precisely what works to stop it, we know that what society is doing at the moment isn't working particularly well as a prevention tool. That means our best bet is likely to be developing a conceptual model of what we think is going on, identifying and working with promising programmes and making a commitment to monitor and improve our activities until we get it right. This document is an attempt at this process. It joins with a substantial array of local and international reviews that have also sought to summarise this vast and complex area (Chalk and King 1998; Davies, Kozoi-McLain, Casey, Fanslow, Hassall and Crothers 2002; Krug et al 2002; Davies, Hammerton, Hassall, Fortune and Moeller 2003).

Not one of these documents provides 'the answer' because there probably isn't one answer; there are likely to be many. But because the research field evolves relatively slowly, there is likely to be limited value in commissioning further reviews at this time. We keep looping back to the same literature, and coming up with the same tentative conclusions. So if we want to advance the field at this point we may just have to take our best informed guesses, try them and see.

In Section 7, one of the primary theoretical models (the ecological model) used to explain violence is integrated with another conceptual model (the co-ordinated community action model). The resulting conceptual framework can be used to integrate understanding of current and planned interventions.

It is argued that we need to move beyond zero tolerance for violence, and actively seek to develop and promote positive healthy relationships. By developing a common framework for conceptualising violence prevention activity, it is hoped that practitioners, service providers, researchers and policy-makers may develop clearer understandings of the roles they fill in preventing and responding to violence and how they interface with other groups. Through this we may develop a better understanding of the gaps in our current systems and social structures and direct future action. This report concludes with a series of recommendations for research, policy and practice.

A summary of previous government and community activities for the intervention and prevention of family violence is also included, presented as a timeline (Section 11).

This report was prepared over the period mid-April to 30 June 2005 by one author. A summary of the author's background is presented in Appendix A.

1.1 TOPICS NOT INCLUDED

This report does not include a review of primary prevention programmes and media campaigns designed to prevent violence. A comprehensive review of these activities was undertaken by a team from the Auckland University of Technology, to inform the development of Te Rito Action Area 13 (Davies et al 2003). Where appropriate, conclusions from that report will be included in this document. This report also excludes a review of best practice on therapy, treatment and rehabilitation guidelines for victims and perpetrators.

Additionally, this report does not provide a comprehensive review of current government activities responding to family violence. These are summarised in the New Zealand Parliamentarians' Group on Population and Development (NZPPD) report *Creating a Culture of Non-violence* (NZPPD 2005). While every effort has been made to include the most up-to-date information, some of the newest initiatives may not have been included.

1.2 CULTURAL PERSPECTIVES

This report is written from a Pākehā/white western cultural perspective, and draws primarily from published literature developed in that cultural tradition. Specific discussions of alternate cultural perspectives on family violence are not included because they are outside of the author's area of expertise and the timeframe for this report precluded obtaining additional expertise.

Readers seeking further information on these issues are referred to Kruger et al (2004), *Transforming Whānau Violence – A Conceptual Framework*; Pihama, Jenkins and Middleton (2003), *Family Violence Prevention for Māori Research Report*; and Kim (2002), *Innovative Strategies to Address Domestic Violence in Asian and Pacific Islander Communities: Examining themes, models and interventions*.

It is worth noting that cultural understanding alone is insufficient to broker adequate responses to family violence; dual competency and understanding of family violence as well as cultural issues is required (Pihama et al 2003; Gondolf 2005).

2. METHODS

2.1 METHODS FOR REVIEW OF CHILD ABUSE, INTIMATE PARTNER VIOLENCE AND ELDER ABUSE (SECTIONS 3-6)

Due to the volume of published material in this field, access and reading of material was restricted to review articles and books whenever possible. The timing of this report was opportune, as one key journal was celebrating its 20th year of publication with a series of review articles. Identified articles were supplemented by resources from the author's library, in particular those related to New Zealand work. In addition, this report draws heavily upon key resources developed by the US National Research Council (NRC) (Chalk and King 1998) and the World Health Organization (WHO) (Krug et al 2002). Books prepared by these organisations, involving extensive teams of scientists over multiple years, review and summarise the primary literature in a way that was beyond the scope of this report.

The published literature was searched using the databases and search strategies shown in this table:

DATABASE	SEARCH STRATEGY 1	STRATEGY 2
MEDLINE	exp domestic violence (prevention and control) and intervention limit: review articles	exp domestic violence and (consequences or sequelae) limit: review articles
PSYCHINFO	exp family violence and (early intervention or prevention) and review	exp family violence and (consequences or outcomes or sequelae) limit: literature review
EMBASE	(exp family violence or exp battered women or exp domestic violence) and prevention and review	
CINAHL	exp domestic violence and prevention limit: review articles	exp domestic violence and (consequences or outcomes or sequelae) limit: review articles
Sociological Abstracts		family violence and (consequences or outcomes)

Words shown in bold indicate index terms available in that database. In these databases the terms 'domestic violence' and 'family violence' respectively are exploded to include the narrower terms 'child abuse', 'elder abuse' and 'spouse abuse'. The searches were further limited to articles published in the period 1995-2005 and to English language articles. The citations retrieved were scanned for meta-analyses, systematic reviews or articles providing a substantive review of the topic. Just one Cochrane Review was retrieved. The internet was also searched for publications from such agencies as the WHO, the US Center for Disease Control and Prevention (CDC) and the Australian Domestic and Family Violence Clearinghouse.

2.2 METHODS FOR DEVELOPMENT OF SECTIONS 7-9

These sections represent the author's thinking about ways to integrate two of the key conceptual models in the family violence field. The author seeks to do this in a way that acknowledges the complexities and inter-relationships of multiple sectors of society, and the different ecological levels that influence the likelihood of family violence. The author also seeks to demonstrate how use of this conceptual framework can guide our thinking for enhancing current family violence prevention and intervention efforts for family violence as well as serving as a platform for identifying future directions for action. Section 8 seeks to draw together the information from all sections in a final summary and Section 9 presents recommendations for future action.

2.3 METHODS FOR DEVELOPMENT OF TIMELINE OF FAMILY VIOLENCE PREVENTION INITIATIVES IN NEW ZEALAND (SECTION 11)

A timeline of government and community family violence activities covering the period from the 1960s to 1993 was prepared by the Family Violence Advisory Unit in 1994. This forms the basis of the first part of the timeline in this report. Subsequent entries were derived from literature searches and review of government websites, supplemented by general knowledge of the field. A draft of the timeline was circulated to national Non-Government Organisations (NGOs) for comment, in an effort to ensure that key community activities were identified.

2.4 DEFINITIONS OF FAMILY VIOLENCE

Te Rito, New Zealand Family Violence Prevention Strategy (Ministry of Social Development 2002) defines family violence as

encompassing a broad range of controlling behaviours, commonly of a physical, sexual and/or psychological nature and which typically involve fear, intimidation and emotional deprivation. It occurs within a variety of close interpersonal relationships, such as between partners, parents and children, siblings, and in other relationships where significant others are not part of the physical household but are part of the family and/or are fulfilling the function of family.¹

In addition, the strategy lists commonly recognised sub-groupings of violence in families/whānau. These are:

- > child abuse/neglect (abuse/neglect of children by an adult)²
- > spouse/partner abuse/intimate partner violence (violence among adult partners)
- > elder abuse/neglect (abuse/neglect of older people aged approximately 65 years and over, by a person with whom they have a relationship of trust)³
- > parental abuse (violence perpetrated by a child against their parent)
- > sibling abuse (violence among siblings).

Because of the dearth of information about parental abuse and sibling abuse these issues are not discussed in this report.

¹ This definition is consistent with the *Government Statement of Policy on Family Violence* (Department of Prime Minister and Cabinet and Department of Social Welfare 1996), and the Domestic Violence Act 1995.

² Child abuse/neglect also occurs outside the family.

³ Elder abuse/neglect also occurs outside of the family.

Within each of these categories, types of violence that can be inflicted include physical, sexual and psychological abuse. While often measured and discussed separately, these categories and types of violence often do not occur in isolation. In addition to physical, sexual and psychological abuse, other types of abuse have become increasingly recognised. For example, older persons are particularly vulnerable to experiencing financial/economic abuse.⁴ In relation to a child, psychological abuse can occur where the child has witnessed the physical, sexual or psychological abuse of another.

2.5 CAVEATS AND ISSUES AROUND DEFINITIONS

Precision of definition and terminology is important to provide conceptual clarity and specificity. It is also an area of considerable challenge in this field, which has a complicated lexical history, including terms like ‘domestic violence’ (sometimes used synonymously with family violence, sometimes used to describe just intimate partner violence), ‘spouse abuse’ (disguising the fact that non-married partners can also be victims or perpetrators of violence), etc.

In New Zealand social policy statements, ‘family’ has sometimes been used interchangeably with ‘whānau’, a fact that indicates that these terms are not well understood or are viewed as the same construct (Kruger et al 2004). Additionally, while family violence is often used as the overarching category to describe violence between those who have (or have had) some ongoing relationship to each other, our measurement tools often do not identify these relationships, or include cases based on some other criteria such as the age of victim, rather than relationship between victim and offender.

Further, while many of the definitions we use indicate that psychological/emotional abuse is often an aspect of violent relationships, our measures of incidence and prevalence are often based solely on assessments of experience of physical violence and/or sexual violence. As a consequence, the majority of incidence and prevalence estimates presented in this document only refer to estimates of physical and/or sexual violence. This is not to imply that psychological violence is unimportant, but merely reflects the limited data on this aspect of violence at present. Some international standards of definitions have been developed, in order to promote consistency. These include definitions of intimate partner violence (Saltzman, Fanslow, McMahon and Shelley 1999) and sexual violence (Basile and Saltzman 2002).

⁴ Financial/economic abuse is a means of maintaining economic power over the victim and includes any illegal or financial exploitation, control of funds and other resources needed for economic and personal survival, and forcing the victim to become financially dependent on the abuser (Browne and Herbert 1997; Age Concern NZ 2002).

3. CHILD ABUSE

3.1 DEFINITIONS

The Children, Young Persons and Their Families (CYPF) Amendment (No. 121) Act 1994 defines child abuse as “the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect, or deprivation of any child or young person”.

The US National Clearinghouse on Child Abuse and Neglect (NCCAN) defines child abuse and neglect as, at minimum (NCCAN 2005):

- > any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation
- > an act or failure to act which presents an imminent risk of serious harm.

Physical abuse is physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap or other object), burning or otherwise harming a child. Such injury is considered abuse regardless of whether the caretaker intended to hurt the child.

Sexual abuse includes activities by a parent or caretaker such as fondling a child’s genitals, penetration, incest, rape, sodomy, indecent exposure and exploitation through prostitution or the production of pornographic materials.

Emotional abuse is a pattern of behaviour that impairs a child’s emotional development or sense of self-worth. This may include constant criticism, threats or rejection, as well as withholding love, support or guidance. Emotional abuse is often difficult to prove and, therefore, Child Protective Services may not be able to intervene without evidence of harm to the child. Emotional abuse is almost always present when other forms are identified.

Neglect is failure to provide for a child’s basic needs. Neglect may be:

- > physical (eg failure to provide necessary food or shelter, or lack of appropriate supervision)
- > medical (eg failure to provide necessary medical or mental health treatment)
- > educational (eg failure to educate a child or attend to special education needs)
- > emotional (eg inattention to a child’s emotional needs, failure to provide psychological care or permitting the child to use alcohol or other drugs).

NCCAN (2005) also advises that these situations do not always mean a child is neglected. Sometimes cultural values, the standards of care in the community, and poverty may be contributing factors, indicating the family is in need of information or assistance. When a family fails to use information and resources, and the child’s health or safety is at risk, then child welfare intervention may be required.

While all definitions in this area share commonalities (usually covering the areas of physical, sexual, psychological/emotional abuse and neglect), there are sometimes differences in the age cut-off used. For example, some define ‘children’ as aged 0-14 years, and ‘young people’ as aged 14-17 years (Fanslow 2002). The Department of Child, Youth and Family Services (CYF) includes children as aged 0-17 years (Ministry of Social Development (MSD) 2004b). Differences in definitions used (eg whether or not ‘neglect’ or psychological/emotional abuse is measured and included in reports of child abuse, as well as differences in age groups included) can lead to challenges comparing statistics between studies or services. Definitions can also vary in terms of relationship categories included, with some restricting their definitions of child abuse or neglect to incidents perpetrated by parents, caregivers or other family members, while other measures include abuse by any adult.

3.2 INCIDENCE AND PREVALENCE

According to the New Zealand Health Information Service (NZHIS), in 2000 and 2001 nine children each year were victims of homicide. In 2003, 116 children were hospitalised as the result of assault (NZHIS 2003). NZHIS data do not identify the relationship between perpetrator and victim of the homicide or assault, so it is not possible to identify the percentage of these deaths and hospitalisations that are the result of child abuse by a parent or other caregiver.

The Social Report (MSD) presents data about the number of children assessed as abused (physically, emotionally, sexually) or neglected following a notification to CYF.

The Social Report 2004 indicated that in the year to June 2003:

- > There were 31,781 care and protection notifications to CYF. On a population basis, this represented 31.8 notifications per 1,000 children aged 0-16 years.
- > 7,361 children were assessed as abused or neglected by CYF. This was a substantiated child abuse rate of 7.4 children for every 1,000 children 0-16 years of age.

These statistics make it clear that large numbers of cases are being processed by CYF. However, service-based statistics can be influenced by systemic changes that may affect CYF's ability to respond to and assess cases such as resources, changes in administration and reporting patterns. Additionally, more than one notification can be made for the same child. We also know, however, that not all instances of child abuse are reported to CYF. For these reasons, these statistics cannot be used as indicators of change in the actual incidence rate of child abuse over time (*The Social Report 2004*).

In a comparison of OECD countries, New Zealand has been reported as having 1.2 deaths per 100,000 children, compared with an OECD median of 0.6 deaths per 100,000 (UNICEF 2003). While this is concerning, and attracted considerable media attention on its release, the comparative findings need to be treated with caution, as small numbers can produce highly volatile rates (even though they are based on five-year averages). Inter-country comparisons can also be difficult, as there may be differences between countries in standards of classification and reporting, as well as differences within countries over time (Ministry of Social Development 2005b).

Data from cohort studies suggest that:

- > Four percent of a cohort of New Zealand children reported experiencing harsh or severe physical punishment from one or both parents before the age of 16 years (Fergusson and Lynskey 1997, cited in Ministry of Health 1998).
- > An estimated 19 percent of girls and 25 percent of boys experienced regular physical punishment from one or both parents before the age of 16 years (based on self-reports at age 18 and 21 years) (Fergusson, Horwood and Woodward 2000).
- > An estimated 18 percent of New Zealand children experienced sexual abuse by any perpetrator (not just a family member) before the age of 16 years (based on self-reports at age 18 and 21 years). Estimates were higher for girls at 25-30 percent compared to approximately six percent for boys (Fergusson et al 2000).

There are no routinely collected population-based statistics that document the incidence or prevalence of child abuse and neglect in New Zealand. Data from the United States suggest that 4 percent of children had experienced severe physical punishment (in the form of being hit with an object, not on the buttocks) within the previous six months. Data from other countries (Chile, Egypt, India and the Philippines) indicate that reported

rates of these behaviours are much higher than those reported in the USA (*WorldSAFE* study, cited in Krug et al 2002).

In the absence of routinely collected, population-based statistics on this issue, it is difficult to track if there are increases or decreases in the rates of child abuse over time. Even the crudest indicators (deaths and hospitalisations) are subject to classification problems and are not always sufficiently detailed to distinguish assault from unintentional injury, or do not specify the relationship between the perpetrator and the victim. Despite these limitations, however, mortality may be the best basis for comparison between populations and over time.

3.3 CONSEQUENCES OF CHILD ABUSE AND NEGLECT

Child abuse creates problems for individuals in terms of short-term health consequences (eg injury), but also places individuals at increased risk of a variety of long-term health problems, through increasing the odds that individuals will engage in a variety of risk-taking behaviours such as taking up smoking or poor diet. The increased risk of adverse outcomes is substantial, with many documented effects indicating that child abuse places individuals at two-fold or higher risk than those not abused. A summary of some of the documented health consequences of child abuse is presented in Table 3.1 (Krug et al 2002).

TABLE 3.1: CONSEQUENCES OF CHILD ABUSE

Physical	Abdominal/thoracic injuries Brain injuries Bruises and welts Burns and scalds Central nervous system injuries Disability Fractures Lacerations and abrasions Ocular damage Neurodevelopmental problems*
Sexual and reproductive	Reproductive health problems Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse Cognitive impairment Delinquent, violent and other risk-taking behaviour Depression and anxiety Developmental delays Eating and sleep disorders Feelings of shame and guilt Hyperactivity Poor relationships Poor school performance Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Suicidal behaviour and self-harm

TABLE 3.1: CONSEQUENCES OF CHILD ABUSE (continued)

Other longer-term health consequences	Cancer Chronic lung disease Fibromyalgia Irritable bowel syndrome Ischaemic heart disease Liver disease
Other consequences	Reduced educational attainment and annual earnings**

Source: *World Report on Violence and Health, Krug et al 2002.*

*Perry 2002.

**Hyman 2000.

Recent data suggest that experience of child abuse may play a role in the later development of chronic diseases, such as cancer, ischaemic heart disease and chronic lung disease (Felitti et al 1998), some of New Zealand's leading causes of death. The apparent mechanism to explain these results is the adoption of behavioural risk factors such as smoking, alcohol abuse, poor diet and lack of exercise. Recognition of the underlying role that child abuse may play in these behaviours may assist us to design programmes that better reach populations that have not responded to currently established programmes.

There are also social consequences associated with child abuse, with a variety of studies indicating that children who have been abused are at greater risk of later aggression both at home and at school (Weiss et al 1992, cited in Stevenson 1999), violent behaviour (Fergusson and Lynskey 1997), and delinquency (Widom 2001; Quas, Bottoms, Nunez and Narina 2002). More recently, research has begun to document the detrimental effects of abuse on other aspects of later functioning, including lower educational attainment and lower annual earnings (Hyman 2000).

Adults abused as children are also at increased risk of abusing their own children, with one prospective study of the long-term effects indicating that the risk of being abusive to one's own children increased from 5 percent (among those not abused as children) to 30 percent (among those who had experienced abuse as children) (Kaufman and Zigler, cited in Margolin 2005). However, because abuse tends to co-occur with a variety of other adverse circumstances in childhood (eg economic disadvantage, family dysfunction) it can be problematic to determine the relative contribution of abuse alone to later impaired functioning. Children exposed to multiple adverse experiences face by far the highest risk of later adverse outcomes (Fergusson and Horwood 2001).

Kendall-Tackett (2002) describes behavioural, social, cognitive and emotional pathways that may explain why adverse health problems are more likely for abuse victims. She reports that behavioural pathways are the most direct, and are clearly linked to the fact that adult survivors of child maltreatment are more likely to engage in harmful behaviours than non-victims. Some of these behaviours include: substance abuse, obesity and eating disorders, high-risk sexual behaviour (eg higher incidence of unprotected sex, multiple sexual partners), suicide attempts and ideation, smoking and sleep difficulties.

Social pathways to ill-health include a variety of relationship difficulties, such as social isolation and poor social connections, re-victimisation and homelessness. Some of these may result from the fact that abuse victims are more likely to adopt dysfunctional interpersonal styles (eg avoidant or intrusive).

Cognitive pathways to ill-health include adoption of 'internal working models' that represent the world as a dangerous place, and leave the survivors feeling high levels of anxiety, paranoia, hostility and lack of trust. Survivors of child abuse also have poor self-rated health, which is in itself a predictor of illness and mortality.

Emotional pathways to ill-health include the two most commonly reported symptoms of past abuse: depression and post-traumatic stress disorder. Not only is depression more common among abuse survivors, but depression itself can have severe and dramatic effects on health, including immuno-suppression, failure to engage in health-promoting activity, negative impacts on sleep and increased risk of coronary heart disease (Kendall-Tackett 2002).

These pathways can occur individually and in combination, and are likely to vary for each individual. Understanding these possible pathways, however, increases the likelihood that clinicians can work to improve health outcomes for survivors. Identifying clients who have experienced abuse can provide important contextual information so that clinicians can assess the most appropriate treatment and referral options to provide. As Kendall-Tackett (2002) points out:

admonitions to abstain from smoking or substance abuse are unlikely to be successful until the traumatic events driving these behaviours have been addressed and resolved. Admonitions to exercise are unlikely to be effective if the patient believes that nothing he/she does will make a difference. And telling someone to lose weight may be setting an individual up for further failure if she/he has limited ability to make and keep friends, and eats when lonely or stressed.

3.4 RISK AND PROTECTIVE FACTORS

From a public health perspective, one of the first steps to designing effective interventions is to look for risk factors (those factors associated with the behaviour that make it more likely to occur) and protective factors (those that make it less likely to occur). Information on these factors in relation to child abuse is summarised in Table 3.2.

Four points are notable from this summary of risk factors. First is the gendered nature of perpetration of the most serious physical violence and of sexual abuse, as these are predominantly perpetrated by men. Women are more likely to report using physical discipline than men (Krug et al 2002).

The second point to note is that the constellation of risk markers indicate that many forms of child abuse cluster around disadvantaged individuals and families characterised by poverty, low levels of education, unstable family environments and a variety of individual personality and behavioural characteristics. These findings are consistent with the risk markers identified for many other health and social problems. However, they cannot be viewed as predictive of child abuse because of the difficulty disentangling the directionality and co-occurrence of many of these markers (eg low education may lead to unemployment, which may contribute to antisocial behaviours, which may lead to child abuse, which may contribute to low self-esteem). They are more likely to be useful for identifying some of the target population groups where interventions might most profitably be directed, and some of the broader-scale environmental factors that could reduce the occurrence of abuse such as poverty reduction and reductions in unemployment.

Thirdly, we need to develop better understanding of resilience factors. The concept of resilience is broader than simply the absence of risk factors. Margolin (2005) has identified some of these resilience factors as follows:

- a. help to shield the child from the stressor
- b. facilitate sustained adaptation despite exposure to the stressor
- c. promote recovery.

Some resiliency factors may be innate and unchangeable (eg intelligence, which typically fosters good functioning). Other resiliency factors may be helpful in some circumstances and less helpful in others. For example, coping strategies that children adopt in response to violence between parents, like using avoidant or withdrawing coping strategies (eg tuning out or extricating themselves) may be helpful in that circumstance, but may not be effective in responding to problems at school. Other resiliency factors may relate more to the family (emotional or physical resources) or social context in which the child lives (eg presence of a supportive adult in the child's life, neighbourhood connection).

At present, we have little knowledge of what these resilience factors are, let alone how they interact, in order to best interrupt the pathways between experience of violence and future problem behaviours (Margolin 2005).

The fourth point to note about Table 3.2 is the lack of empirically supported protective factors, particularly at the community and societal level. This does not imply that these factors are not important; merely that, to date, they have not been the subject of intensive investigation. Given our increasing awareness of how interactions between individuals and their immediate and wider environments operate in complex ways, risk and protective factors at these levels merit serious attention. The evidence that social networks and neighbourhood connections can be protective against violence, even in the presence of individual level risk factors, provides glimpses of positive supports that can be built around at-risk individuals (Runyan 1998, cited in Krug et al 2002).

TABLE 3.2: RISK AND PROTECTIVE FACTORS FOR CHILD ABUSE AND NEGLECT

OUTCOME	CHILD FACTORS	PARENT/CAREGIVER FACTORS	FAMILY ENVIRONMENT FACTORS	COMMUNITY FACTORS	SOCIETAL FACTORS (PROPOSED)
Fatality	Under two years	Men most common perpetrators		Poverty, communities with deteriorated physical and social infrastructure	The role of cultural values and economic forces in shaping the choices facing families and shaping their response to these forces Inequalities related to sex and income – factors present in other types of violence and likely to be related to child maltreatment as well Cultural norms surrounding gender roles, parent-child relationships and the privacy of the family Child and family policies – such as those related to parental leave, maternal employment and childcare arrangements The nature and extent of preventive health care for infants and children, as an aid in identifying cases of abuse in children The strength of the social welfare system – that is, the sources of support that provide a safety net for children and families The nature and extent of social protection and the responsiveness of the criminal justice system Larger social conflicts and war
Sexual abuse	Post puberty girls (higher risk, but also young children)	Men most likely perpetrators Family (maternal) support following disclosure (being believed, mothers acting in a protective manner) associated with better outcome		Social capital as a protective factor (social networks and neighbourhood connections)	
Harsh physical abuse	Boys	Men most common perpetrators of life-threatening head injuries and abusive fractures			
Physical abuse and neglect	6-12 years, highest rates in USA Premature infants, twins and handicapped children*	Women report using more physical discipline Low self-esteem Poor impulse control Mental health problems Antisocial behaviour Unrealistic expectations about child development Prior history of abuse**	Social isolation Young, single, poor, unemployed Low education Unstable family environments Intimate partner violence in home Stress		

Source: *World Report on Violence and Health, Krug et al 2002.*

*These characteristics may not be major factors for abuse when parental and societal variables are considered.

**Empirical data suggest a link, but other factors (eg young age, stress, isolation, overcrowding, poverty) may be more predictive.

3.5 INTERVENTION AND PREVENTION STRATEGIES

Interventions for child abuse have been reported in a broad range of sectors, including family support, health services, therapeutic approaches, legal and related interventions, community-based efforts and societal approaches. In the majority of cases these interventions have not been evaluated, have not demonstrated positive results or have produced mixed results. Some have assessed proximal outcomes associated with programmes (eg changes in knowledge) but have not assessed effectiveness in terms of actual reductions in child abuse or improved outcomes for victims (Krug et al 2002). This section reviews some of the intervention and prevention strategies for child abuse that have been tried or are in place in New Zealand. It follows the framework of interventions outlined in the *World Report on Violence and Health*.

3.5.1 Home visitation

A part of a comprehensive prevention strategy for child maltreatment, the US National Research Council recommended that:

home visitation programmes should be encouraged for first time parents living in social settings with high rates of child maltreatment reports. However, further evaluation is required to determine the combination of factors that are most likely to enhance the effectiveness of such programmes including

1. the conditions under which the home visitation services are provided
2. the types of parenting behaviours that are most and least amenable to change
3. the duration and intensity of services necessary to achieve positive outcomes (include amount and types of training of visitors)
4. the experiences of fathers, and of families from diverse ethnic communities
5. the need for follow-up services once the period of home visitation has ended (Chalk and King 1998) (see Box 3.1).

BOX 3.1: EARLY CHILDHOOD HOME VISITATION PROGRAMMES

Home visitation programmes include visits by trained personnel during at least part of the first two years of a child's life, and include one or more of the following:

1. training of parent(s) on prenatal and infant care
2. training on parenting to prevent child abuse and neglect
3. developmental interaction with infants and toddlers
4. family planning assistance
5. development of problem-solving and life skills
6. educational and work opportunities
7. linkage with community services.

Home visitation programmes must also be 'multicomponent' and include day care, parent group meetings, transport, etc. Some programmes have been offered to specific population groups (usually those considered high risk), but are universally available in some countries.

Results

There is strong evidence of the effectiveness of some of these programmes on the prevention of child abuse and neglect, reducing reported maltreatment by approximately 39 percent. Positive effects of some programmes have been noted 15 years after the intervention. Programmes delivered by professional visitors (nurses or mental health workers) seemed to yield greater effects than those delivered by paraprofessionals. For paraprofessional visitors, effects are mixed, and beneficial effects are generally found in programmes of longer duration (more than two years). Positive effects other than reductions in violence have also been noted with home visiting programmes, including decreases in the incidence of drug use, the number of sexual partners, and the number of long-term school suspensions. Many of these positive benefits were maintained in the children of low income single mothers. Additional benefits have been claimed for the programmes – such as children's cognitive, emotional and physical development, school achievement, and immunisation coverage – but these have not been comprehensively reviewed. One economic evaluation showed that, for the low income sub-sample of the group, government benefits more than offset programme costs.

BOX 3.1: EARLY CHILDHOOD HOME VISITATION PROGRAMMES (continued)

Caveats

As the programmes examined were heterogeneous, there are still issues to be determined around the content and delivery of the programmes; which components are essential and which might provide added value, the optimal number, spacing and duration of visits, staff training, and essential curriculum components. The applicability of the findings to diverse populations (high-risk versus the general population, diverse ethnic groups) also needs to be determined. The potential risk of stigmatisation of selected groups, which could have negative impacts on the programme and on programme participants, also needs to be considered. Some programmes report high levels of client attrition, which limits not only the effectiveness of the programme, but the ability to evaluate it.

Summary

There is strong evidence that certain early childhood home visitation programmes are effective at preventing child maltreatment at a modest level of severity and among those people able to be recruited and retained in the programmes. Currently, the strongest evidence exists for programmes delivered to high-risk groups. Well-resourced and well managed programmes delivered by professionals (nurses or mental health workers) seemed to yield greater effects. For programmes delivered by paraprofessionals, effects are mixed, with beneficial effects generally found in programmes of longer duration.

Source: Bilukha et al 2005.

3.5.2 Training in parenting

Other interventions for improving parenting practices and providing family support have been developed. These programmes can vary in terms of how they are targeted (eg aimed at high-risk families or universally available) and in terms of how they are delivered (eg home-based, childcare centre-based, or mixed-delivery programmes incorporating not only early childhood-related content but also skills, education and employment components for adults) (Kerlake Hendricks and Balakrishnan 2005). The common principle is that all of these types of programmes generally educate parents on child development and help them improve their skills in managing their children's behaviour (Krug et al 2002). Evidence of the effectiveness of these programmes in reducing child abuse is not conclusive, in part because of the nature of the evaluations that have been conducted, compounded by logistical issues such as difficulties following up families who are often highly mobile.

For families where child abuse has already occurred the primary goal is to prevent further abuse, as well as other negative outcomes for the child, such as emotional problems or delayed development. Krug et al (2002) report that:

evaluations of programmes on education and training in parenting have shown promising results in reducing youth violence, but few studies have specifically examined the impact of such programmes on rates of child abuse and neglect. Instead, for many of the interventions, proximal outcomes – such as parental competence and skills, parent-child conflict and parental mental health – have been used to measure their effectiveness.

Where well-conducted studies have been undertaken, there is evidence that parenting programmes can result in significant gains. Krug et al (2002) cited a study by Wolfe et al that evaluated a behavioural intervention to provide training in parenting for families considered at risk. Mother-child pairs were randomly assigned to either an intervention group or a comparison group. The intervention group of mothers received training in parenting. They reported fewer behavioural problems with their children and fewer adjustment problems associated with potential maltreatment than mothers in the comparison group. Still more encouraging were the data from a follow-up evaluation by the caseworkers that showed there was a lower risk of maltreatment by the mothers in the intervention group.

The Families Commission recently commissioned a review of parenting programmes in New Zealand (Kerslake Hendricks and Balakrishnan 2005). This review identified a range of parenting programmes that are currently operating in New Zealand, including those geared towards serving the needs of high-risk families such as Family Start and Parents as First Teachers as well as those which are universally available such as Well Child/Tamariki Ora delivered by Plunket. Other programmes are available for specific population groups, such as Anau Ako Pasifika and Whānau Toko I Te Ora, or in particular settings, such as parenting programmes in prison administered by the Department of Corrections. In addition to government-funded programmes, parenting programmes are also offered by the community/voluntary sector such as Barnardos and Presbyterian Support Services. The review also identified issues with the geographic coverage of these programmes (eg small rural communities are often not well served), and identified challenges associated with families' engagement with, retention in and attrition from the programmes.

Currently, there are moves in New Zealand to develop an overall strategy for providing support to parents. This will require collaboration between the government and non-government sector. The Families Commission review indicated that the development of this strategy will need to be informed by the needs of parents and other caregivers, families, children and practitioners, taking into consideration the needs of specific groups that are often under-represented in parenting programmes such as fathers and grandparents. Clearer identification of the matrix of services and the linkages between them will also need to be undertaken as part of this process.

Key characteristics of successful parenting programmes have been identified in international reviews. A summary is presented in Box 3.2. It is worth noting however that offering parenting programmes to families is inappropriate until their basic accommodation and income needs have been met.

BOX 3.2: CHARACTERISTICS OF SUCCESSFUL PARENTING PROGRAMMES

International (English language) evidence regarding the effectiveness of parenting support programmes identified the following conclusions on what works best:

- > Early interventions report better and more durable outcomes for children; but later intervention is better than none and may help parents under stress.
- > The most effective interventions will have:
 - a strong theoretical base and a clearly articulated model of the predicted mechanism of change
 - measurable, concrete objectives, as well as overarching aims
 - more than one method of delivery
 - close attention to attracting, retaining and engaging parents
 - a variety of referral routes
 - programmes (with manuals) where the core programme is carefully structured and controlled to maintain programme integrity
 - delivery by appropriately trained and skilled staff, backed up by good management and support
 - a parallel focus on parents, families, and children (though not necessarily at the same time).

Source: Moran, Ghate and van der Merwe 2004.

3.5.3 Family preservation

Krug et al (2002) reviewed the data related to family preservation strategies. They reported that:

The purpose of family preservation services is to keep the family together and to prevent children from being placed in substitute care. It is targeted towards families in which child maltreatment has been confirmed, interventions are short (lasting a few weeks or months) and intense, with generally 10-30 hours a week devoted to a particular family, either in the home or somewhere else that is familiar to the child. A broad array of services are usually offered, according to the needs of the family, including various forms of therapy and more practical services such as temporary rent subsidies. An example of such a programme in the United States is Homebuilders, an intensive in-home family crisis intervention and education programme. Families who have one or more children in imminent danger of being placed in care are referred to this programme by state workers. Over a period of four months, the families receive intensive services from therapists who are on call 24 hours a day. The wide range of services being offered includes help with basic needs such as food and shelter and with learning new skills. Evaluations of this type of intervention have been limited and their findings somewhat inconclusive, mainly because of the fact that programmes offer a large variety of services and relatively few studies have included a control group. There is some evidence suggesting that programmes to preserve the family unit may help avoid placing children in care, at least in the short term. However, there is little to suggest that the underlying family dysfunction at the root of the problem can be resolved with short, intensive services of this type. One meta-analysis of several different intensive family preservation programmes found that those with high levels of participant involvement, using an approach that built on the strengths of the family and involved an element of social support, produced better results than programmes without these components.

The US National Research Council stated that:

Intensive family preservation services represent an important part of the continuum of family support services, but should not be required in every situation in which a child is recommended for out-of-home placement. This recommendation is based on the fact that research findings suggest that intensive family preservation services do not show an ability to resolve underlying family dysfunction, or improve child well-being or family functioning in most families (Chalk and King 1998).

In the time available to prepare this report, the author was unable to determine to what extent these approaches are used within New Zealand.

3.5.4 School-based programmes

Krug et al (2002) reported that school-based programmes to prevent child sexual abuse have been incorporated into the regular school curriculum in several countries. The purpose of these programmes was summarised as being:

generally designed to teach children how to recognize threatening situations and to provide them with skills to protect themselves against abuse. The concepts underlying the programmes are that children own and can control access to their bodies and that there are different types of physical contact. Children are taught how to tell an adult if they are asked to do something they find uncomfortable. School programmes vary widely in terms of their content and presentation and many also involve parents or caregivers. There is agreement among researchers that children can develop knowledge and acquire skills to protect themselves against abuse. However, proof of the ultimate effectiveness of these programmes would require showing that the skills learned had been successfully transferred to real-life situations.

Examples of school-based programmes to prevent child sexual abuse include the Stay Safe primary prevention programme in Ireland that is now implemented in almost all primary schools, with endorsement from the Department of Education and religious leaders (MacIntyre and Carr 1999); and the Keeping Ourselves Safe programme in New Zealand (see Box 3.3).

Other New Zealand programmes related to the prevention of violence against children were reviewed in Fanslow, McGregor, Coggan, Bennett and McKenzie 2000. One of the conclusions from this report was that, although programmes are available that demonstrate promising results at least for intermediate outcomes, these programmes are either not universally available or are not universally accessed by schools, and are not delivered across multiple developmental stages. Additionally, because these programmes are geared to the prevention of child sexual abuse, it is not clear what effect they may have on physical or emotional violence.

The most effective sexual abuse primary prevention programmes include the following features (MacIntyre and Carr 1999):

- > maximise parent involvement so that concepts are reinforced at home but also so that children can practise the skills they have learned
- > include a combination of structured activities
- > incorporate concepts appropriate to the target group's developmental level.

BOX 3.3: KEEPING OURSELVES SAFE

Keeping Ourselves Safe (Briggs and Hawkins 1997) is a programme jointly sponsored by the New Zealand Police and Ministry of Education to enable children to keep themselves safe from sexual abuse. It operates through schools and deals with five- to eight-year-old schoolchildren and their families.

Goal To prevent sexual abuse by telling children how to avoid it, how to recognise it and how to escape it.

Programme description Combined instruction, videos, stories, games and problem-solving exercises. Teacher administered and parent supported where possible.

Timeframe Ongoing.

Geographical coverage New Zealand schools that agree to participate.

Highlights Reaches children in their own setting.

Limitations May not reach the hard-to-reach. Unsustained without parental reinforcement. May be setting-specific behaviour, ie in real situations of threat taught behaviour may not be evoked. This hypothesis not tested in this study.

Evaluation results One year post-programme interview found a significant increase in knowledge of safe behaviour compared with pre-programme interview.

Source: Davies et al 2003.

3.5.5 Health service approaches

3.5.5.1 Screening by health care professionals

Health care professionals have a key part to play in identifying, treating and referring cases of abuse and neglect and in reporting suspected cases of maltreatment to the appropriate authorities. It is imperative that cases of child maltreatment are detected early on in order to minimise the consequences for the child and to enlist the necessary services as soon as possible (Office of the Commissioner for Children 2000; Krug et al 2002).

However, screening for identification of child abuse and neglect cannot realistically be undertaken by health care providers, as it would need to rely on information obtained directly from the perpetrator or from observers, which could place the child at further risk. Instead efforts have tended to focus on improving the early recognition by health care providers of child abuse and neglect, primarily through greater levels of training and education (see below). This approach has also been advocated in New Zealand (*Family Violence Intervention Guidelines*, Fanslow 2002).

3.5.5.2 Training for health care professionals

Krug et al (2002) summarised the evidence related to the training of health care professionals as follows:

Studies in various countries have highlighted the need for the continuing education of health care professionals on the detection and reporting of early signs and symptoms of child abuse and neglect. Consequently, a number of health care organizations have developed training programmes so as to improve both the

detection and reporting of abuse and neglect, and the knowledge among health care workers of available community services. In the United States, for example, the American Medical Association and the American Academy of Pediatrics have produced diagnostic and treatment guidelines for child maltreatment and sexual abuse, and some European countries have also sought to increase training for health care professionals. In some places, health care professionals are required to take a 2-hour course on identifying and reporting child abuse and neglect as a prerequisite to gaining a licence.

The detection of child abuse and neglect, however, is not always straightforward. Specific interview techniques and types of physical examination are generally required. Medical professionals should also be alert to the presence of family or other risk factors that might suggest child abuse. To maintain a continuing and dynamic process of education, some researchers have suggested multi-component, structured curricula for health professionals, according to their particular level of involvement with child abuse cases. Under this proposal, separate but integrated courses of training would be developed for medical students and physicians in training, on the one hand, and for those with a specific interest in child abuse on the other. Evaluations of training programmes have focused principally on the health care worker's knowledge of child abuse and behaviour. The impact of training programmes on other outcomes, such as improved care and referral for children, has not been established.

In New Zealand, education of health care providers as part of their core training has historically been scant or non-existent, but recent efforts by the Ministry of Health have resulted in a number of training programmes for practitioners being delivered through professional colleges. Some training institutions offer minimal training (one to two hours) as part of the core curriculum (eg University of Auckland training for medical students, Auckland University of Technology training for nurses). Efforts by the Ministry of Health and other individuals and advocacy groups have contributed to significant change in the knowledge and awareness of the importance of health care provider response on this topic.

3.5.6 Therapeutic approaches

As described in Section 3.3, the consequences of child abuse and neglect depend on many factors, including the age and developmental level of the child and the presence of environmental stress factors. In an effort to mitigate these consequences, a broad range of therapeutic services has been developed to assist victims with recovery.

3.5.6.1 Services for victims

A review of treatment programmes for physically abused children, summarised in Krug et al (2002), reported that therapeutic daycare designed to improve children's cognitive and developmental skills was commonly used. Therapeutic daycare, incorporating therapy and specific treatment methods as part of a child's daily activities and often including therapy and education for the parents, has been suggested as an approach for mitigating a range of conditions related to abuse, such as emotional, behavioural or attachment-related problems and cognitive or developmental delays.

One well-designed study of this type reported that training children with higher levels of social functioning to engage with more socially withdrawn children resulted in improvements in the social behaviour of withdrawn children (Fantuzzo et al 1988, cited in Krug et al 2002). However, a 1995 review of programmes for treating child physical

abuse indicated that most of the other treatment programmes had reported little or no evaluation (Oates and Bross 1995).

Manifestations of sexual abuse can also vary considerably depending on factors such as the individual characteristics of the victim, the relationship of the perpetrator to the victim and the circumstances of the abuse. As a result, a variety of intervention approaches and treatment methods have been developed to treat child victims of sexual abuse, including individual, group and family therapy. Krug et al (2002) reported that evidence of the effectiveness of these programmes indicated some improvements in mental health, but that there is considerably less information on other benefits.

In the time available to prepare this report, the author was unable to establish the degree to which this type of programme is available in New Zealand.

3.5.6.2 Services for children who witness violence

As recognition increases of the adverse consequences of children witnessing violence, services for these children have been developed. However, evaluations of services for children who have witnessed violence have produced contradictory findings. Krug et al (2002) identified two evaluations of the same 10-week group counselling programme that produced differing results. In one, the children in the intervention group were able to describe more skills and strategies to avoid getting involved in violent conflicts between their parents and to seek out support than the children in the comparison group. In the other evaluation no differences between treatment and comparison groups were observed.

The National Collective of Independent Women's Refuges offers some programmes for children who are housed at Women's Refuges. The Accident Compensation Corporation (ACC) is developing a project to address the needs of child witnesses of violence to be piloted in the Family Safety Team areas (Auckland, Hamilton, Wairarapa, Christchurch and Hutt Valley). The Ministry of Justice offers programmes for children (included in Protection Orders) that have been found to assist children to deal with the effects of domestic violence in their lives, but also reported that the education-based programmes were not able to address underlying family systems problems. In addition to the positive benefits, evaluation indicated that the programmes could be improved by attending to the following:

- > geographical variation in referral patterns to programmes that lead to significant delays in families accessing the programmes
- > limitations to the scope of issues that programmes were able to address in the wider family (eg sibling violence)
- > limitations in those who were eligible to access the programmes (Cargo, Cram, Dixon, Widdowson, Adair and Jackson 2002).

3.5.6.3 Services for adults abused as children

Victims of child abuse may not be identified until much later in life. One New Zealand study reported an average of 16 years before disclosure of sexual abuse (McGregor 2004). As understanding increases of this lag in identification, and of the fact that adverse consequences may not appear until long after the abuse occurred, there has been increased recognition of the need to provide adult survivors with supportive services. Many of these services are provided by mental health providers. Few evaluations have been published on the impact of such interventions for adults who were abused during childhood. Within New Zealand, therapy guidelines for adult survivors of

child sexual abuse have been developed (McGregor 2001). The ACC also registers and funds some counselling for adult survivors of abuse.

3.5.7 Child protection services

Child protection service agencies investigate and try to substantiate reports of suspected child abuse. The initial reports may come from a variety of sources, including health care personnel, police, teachers and neighbours. If the reports are verified, then child protection services staff decide on appropriate treatment and referral. Such decisions are often difficult, since a balance has to be found between various potentially competing demands such as the need to protect the child and the wish to keep a family intact. The services offered to children and families thus vary widely. While some research has been published on the process of decision-making with regard to appropriate treatment, as well as on current shortcomings – such as the need for specific, standard criteria to identify families and children at risk of child abuse – there has been little investigation of the effectiveness of child protection services in reducing rates of abuse (Krug et al 2002). These services are provided in New Zealand by CYF.

3.5.8 Child fatality review teams

Increased awareness of severe violence against children has led to the establishment of teams to review child fatalities in many states in the US. These multidisciplinary teams review deaths among children, drawing on data and resources of the police, prosecution lawyers, health care professionals, child protection services and coroners or medical examiners. One of the objectives of this type of intervention is to improve the accuracy of classification of child deaths. Improved accuracy of classification in turn may contribute to more successful prosecutions through the collection of better evidence. Other review team objectives include preventing future child deaths from maltreatment through review, analysis and putting in place corrective actions, and promoting better co-ordination between the various agencies and disciplines involved (Krug et al 2002).

Internationally, researchers have found that these specialised review teams are more likely to detect signs of child abuse and neglect than those without relevant training. In one example from the United States (Luallen, Rochat, Smith, O’Neil, Rogers and Bolen 1998), researchers found that child fatality reviews were most sensitive to death from maltreatment and sudden infant death syndrome. After investigation by the child fatality review team, 2 percent of deaths during the study year not initially classified as related to abuse or neglect were reclassified as due to maltreatment.

In New Zealand, the first Child and Youth Mortality Review Committee (CYMRC) was appointed by the Minister of Health in September 2001. The vision of the committee is to reduce the number of preventable deaths in New Zealand’s children and youth and to work in partnership with Māori communities. The committee reviews all deaths of individuals aged from 28 days to 24 years. Its first report to the Minister of Health is available. The summary indicates that the main cause of death for this age group was unintentional injuries. Intentional injuries (due to interpersonal violence) were not mentioned in the summary (CYMRC 2005).

3.5.9 Mandatory and voluntary reporting

The reporting by health professionals of suspected child abuse and neglect is mandated by law in various countries, and voluntary in others’ reporting laws (Bross et al 2000, cited in Krug et al 2002). The effectiveness of these laws for preventing child abuse is not known, although mandatory reporting laws are potentially useful for data-gathering

purposes. Mandatory reporting guidelines have also been the subject of concern such as whether under-funded social agencies are in a position to benefit the child and his or her family, and whether instead they may do more harm than good by raising false hopes.

3.5.10 Arrest and prosecution policies

Criminal justice policies vary markedly, reflecting different views about the role of the justice system with regard to child maltreatment. The decision whether to prosecute alleged perpetrators of abuse depends on a number of factors, including the seriousness of the abuse, the strength of evidence, whether the child would make a competent witness and whether there are any viable alternatives to prosecution. Studies identified by Krug et al (2002) indicated that a sizeable percentage of alleged cases of sexual abuse are not accepted by prosecutors, or do not progress to formal charges.

3.5.11 Treatment for offenders

In New Zealand, treatment options for child sex offenders fall into three main groups: prison-based sex offender treatment units (such as Kia Marama at Rolleston Prison and Te Piriti at Auckland Prison); community provider programmes; and individual intervention through a psychologist.

The prison-based programmes have consistently reported strong evidence of effectiveness in reducing re-offending, with a 2002 Canadian review of sex offender programmes ranking Kia Marama alongside the most effective treatment programmes available (Hanson et al 2002).

The community-based programmes are funded by a number of agencies, including the Department of Corrections, CYF and other community funding sources. The programmes are run by Auckland-based SAFE Network Inc., STOP Wellington Inc. and STOP Trust Christchurch. Evaluation of these programmes indicated that participants who completed the community-based programmes had a 5.2 percent recidivism rate, compared to a 16 to 21 percent recidivism rate for untreated child sex offenders (Lambie and Stewart 2003).

Court-mandated treatment for child abuse offenders is an approach recommended in many countries. There is debate among researchers as to whether treatment mandated through the court system is preferable to voluntary enrolment in treatment programmes. Mandatory treatment follows from the belief that, in the absence of legal repercussions, some offenders will refuse to undergo treatment. Against that, there is the view that enforced treatment imposed by a court could actually create resistance to treatment on the part of the offenders, and that the willing participation of offenders is essential for successful treatment (Krug et al 2002).

3.5.12 Prevention and educational campaigns

Mass media education and prevention campaigns have been proposed as one approach to reducing child abuse and neglect. The rationale is that increasing awareness and understanding of the phenomenon among the general population will result in a lower level of abuse, either directly – with perpetrators recognising their own behaviour as abusive and wrong and seeking treatment – or indirectly with increased recognition and reporting of abuse either by victims or others.

A multimedia campaign in the Netherlands had the goal of increasing disclosure of child abuse, both by victims and those in close contact with children such as teachers. The campaign included a televised documentary, short films and commercials, a radio

programme and printed materials such as posters, stickers, booklets and newspaper articles. Regional training sessions were provided for teachers. An evaluation of this intervention concluded that the mass media campaign increased the level of disclosure, as measured by the rate of telephone calls to the National Child Line service before and after the campaign. However the effect of increased disclosure on rates of child abuse and on the mental health of the victims has not been established (Hoefnagels and Baartman 1997, cited in Krug et al 2002).

In New Zealand, public awareness campaigns have been conducted on issues such as 'anti-smacking' messages for caregivers, but these have tended to be short-duration, low-intensity programmes, with limited evidence of their effectiveness.

Davies et al (2003) reviewed evidence for the effectiveness of mass media campaigns. They concluded that:

the best campaigns are part of multi-level strategies, with consistent messages conveyed through multiple sources. While campaigns of this sort have been associated with recall or target messages (increased 'knowledge'), assessments of resulting changes in actual attitudes and behaviours has seldom been measured. Sustaining changes in knowledge over time is likely to require sustained effort. Public education of this form is likely to be more effective if focused on 'life-enhancing, action-oriented messages' rather than on more general prevention messages or those that focus on the negative. Risks associated with public education campaigns include those associated with messages focused primarily on the dangers associated with violence (in some cases these have resulted in increase 'pro-violent attitudes'), risks associated with lack of resources to meet increased demand for requests for services.

Davies et al also raised the caution that high-profile campaigns to encourage children to disclose abuse may lead to greater abuser threats to children in order to prevent disclosure. Additionally, as media campaigns and social marketing strategies can be extremely expensive yet produce little effect, it is important that principles of good practice for such efforts are carefully observed. A summary of these is presented in Box 3.4.

BOX 3.4: COMPONENTS OF GOOD PRACTICE IN MEDIA CAMPAIGNS

Define the issues

1. Begin with **clearly stated objectives** to ensure a clear understanding and consensus about the intent of the initiative among all those involved. Being clear about goals provides a specific sense of direction, a unifying theme, and a specific endpoint for a particular effort. Goals also establish a standard to help groups evaluate progress and gain the feedback necessary for the maintenance and operation of the group.
2. The objectives need to be **measurable, realistic and within the capability of the organisation**. If behaviour change is the objective of a media-based intervention, the literature generally agrees that modest goals should be set, and that it is easier to promote a specific behaviour than a more general behaviour.
3. **Gather data** on the problem to indicate its size and justify social action, and to illustrate how the problem is distributed throughout the population.
4. Allow **sufficient time** for organisational acceptance of the proposed strategies.

BOX 3.4: COMPONENTS OF GOOD PRACTICE IN MEDIA CAMPAIGNS (continued)

Know the audience

5. Develop an **audience-centred orientation**, rather than one that focuses on the message to be conveyed. This orientation is achieved by holding formative research activities to understand the audience profile better – their needs, wants, perceptions, lifestyles, living environment and media habits.
6. **Segment the audience** or clientele into clear target groups. Segmentation based on predisposition, motives, values and lifestyle is essential when designing and targeting social marketing activities. Any campaign must also be compatible with the cultural and religious traditions of the target group or groups.
7. Be aware that **audiences may be at different stages** in relation to change. ‘Precontemplators’ are not seeking information so their attention has to be arrested. This will require variation in a pool of advertisements addressing the same theme to avoid quick ‘wear out’ of an advertisement. ‘Contemplators’ on the verge of change and ‘actioners’ will benefit from information on resources and support available, and practical tips on initiating and maintaining change.
8. Seek **participation by representatives from target groups** at the design stage through research and mobilisation activities.

Communicate appropriately

9. **Form partnerships** to enhance credibility and facilitate access to target groups. The audience’s response to a communication will be influenced not only by the content of the message but also by its perceived source.
10. Messages have most impact if they come from **multiple sources of high credibility** and similarity and are repeated often and consistently.
11. Ensure that the **messages are appropriate** to the objectives and to the needs and perceptions of the target audience. Pre-test messages, revise and pre-test again.
12. Incorporate **information pertaining to behavioural alternatives** and skills development within the communication message itself.
13. **Emphasise positive behaviour change** rather than negative consequences. Fear arousing messages may be less effective than positive messages, depending on the audience’s age, anxiety levels, how easy they feel it is to take action, and proximity to the behaviour concerned.
14. **Illustrate the benefits for individuals** in the target group based on their needs and interests, which are not necessarily the same as those of professionals or experts. Focus on immediate rewards rather than avoiding negative consequences in the future. Stress the implications for the individual in terms of everyday existence.
15. **Use a variety of means** to reach target audiences including the media, face-to-face communication and events. The methods selected should be based on an analysis of the target groups’ profiles. As a rule, the communication channels should be ones the target audience comes into contact with on a regular basis and perceives as credible.
16. Repeat the message periodically and **supplement it with interpersonal contacts** and the services associated with them. Personal communication reinforces every other channel and takes on primary importance wherever mass media fail to penetrate or are underused.

Support the campaign

17. **Use partnerships** to help mobilise the human, financial and material resources needed to implement social marketing activities. Allow sufficient time for partnerships to develop.
18. **Coordinate campaigns with direct service delivery**, such as information hotlines and support services. Promote interaction with the audience via telephone or written materials.
19. **Time the introduction of the programme** to maximise support and the efficiency of implementation.
20. **Recognise and support the contributions** of different partners and reassess roles and responsibilities within partnerships regularly.

Recognise barriers to change

21. **Take into account real and perceived barriers** that might prevent people from adopting a new behaviour. These include the time involved and social, cultural, psychological and physical barriers, including fear of side effects or other complications.
22. **Be prepared to modify programmes**, products, services or ideas accordingly. This includes acting on the systems or structures that create the barriers.

Make a long-term commitment

23. Carry out **ongoing monitoring and evaluation** to modify and improve the programme. This includes documenting the impact or outcomes through tracking studies over the long term, for example, up to five years.
24. Make a **substantial and long-term financial commitment**. The extent and duration of financial commitments must be in keeping with the level of change expected. Social change does not take months, but rather years or decades.

Source: Reproduced from Gray 2001: 37-39.

3.5.13 Community development programmes

Community development programmes are attracting increased attention as models to address family violence. Davies et al (2003) identified values underpinning these approaches as:

- > communities in charge of their own development
- > focus on recognition and mobilisation of community skills and strengths
- > respect and understanding of the community is a facet of all stages of planning and implementation
- > planning and implementation are based on best available knowledge, but are also subject to regular review and revision.

The 'saturation community development model', which allows for programmes in multiple sectors, has been promoted as one of the most promising (Davies et al 2003). Examples include the Strong Communities programme that mobilises a whole community with the aim of reducing child maltreatment. It is comprehensive, neighbourhood-based, child-centred and family-focused. The Everyday Communities programme in New Zealand is a developing example (Box 3.5).

BOX 3.5: EVERYDAY COMMUNITIES

One promising community-based programme for the prevention of child abuse in New Zealand is the Everyday Communities (EDC) programme. The programme objectives are:

- > to raise the public's awareness of the issues of child abuse
- > to increase the public's knowledge of the ways to prevent child abuse
- > to redistribute the responsibility across communities for the prevention of child abuse.

EDC, implemented as a partnership between Child Youth and Family and selected communities, involves: a social marketing programme which uses locally appropriate communications to raise awareness and change behaviour; a community development and assets-based approach; working with communities to develop effective strategies based on partnership and participation; and supporting culturally appropriate strands for mainstream, Māori and Pacific peoples.

Evaluation methodologies, including surveys (public, community leaders, community organisations), key informant interviews, community meetings and triangulation with administrative data, have provided evidence of the attitudinal and behaviour changes of the public as well as community (leaders, organisations, churches etc).

Initial conclusions show that the attitudes and some behaviours have changed, suggesting EDC can have an impact in a range of communities.

Source: Dowden, Welsh-Morris and Faalau 2004.

3.6 SUMMARY AND CONCLUSIONS

This section has outlined some of the responses to child abuse that have been developed and trialled in New Zealand and elsewhere. Although much has been tried, and there are some promising approaches that have demonstrated intermediate outcomes that may support reductions in child abuse, only one approach (home visitation) has been identified that has strong empirical support for preventing child abuse among at-risk families that are able to be recruited and retained within a programme. International programmes have provided some evidence that, under certain conditions, parenting support programmes may be effective at reducing stress in families, but a local review indicates that their application needs to be more clearly worked out in New Zealand. School-based programmes for the prevention of child sexual abuse have been shown to increase knowledge, though children's ability to apply this knowledge in real-life situations has not been tested. Community development approaches, such as the Everyday Communities programme, show promise as prevention tools. On the whole, however, there is only limited evidence of the effectiveness of a few programmes.

Does this mean that the other interventions that are being tried, or that are an established part of our response to child abuse, should be abandoned? No. Many service providers have examples of individuals for whom interventions have produced positive results.

What the lack of evidence does attest to is that, in the majority of cases, we have done a very poor job of assessing the efficacy (or possible adverse consequences) of what we do in a way that is scientifically meaningful. Very few studies have been reported that use a

control or comparison group (rather than simply conducting pre- and post-intervention studies on the clients in a specific treatment or prevention programme). Even when this criteria is met, the number of participants in individual studies is often very small, which reduces their strength. Follow-up measures are over short timeframes, and often assess proximal outcomes (eg participants' knowledge or satisfaction with a programme) rather than the outcomes that we are most interested in (eg rates of child abuse). Even where good evaluation studies have been conducted, there is still much to be learned about the specific programme components that can produce optimal outcomes.

Does this mean that all evaluation is useless? No. It does, however, mean that we need to get serious about the evaluations we conduct and the outcomes we measure. At a minimum, this is likely to mean ensuring that new interventions are adequately planned, sufficiently developed and operating well prior to evaluation. Programme fidelity also needs to be demonstrated, to document that programmes are being implemented as intended. The degree of attrition from the programme needs to be minimised, as high levels of attrition can compromise the validity of the evaluation results. Evaluations themselves need to utilise appropriate research designs to enable strong inferences to be made about programme effects, and be sufficiently resourced to ensure that they measure the outcomes we are most interested in.

What is also evident from the interventions reviewed is the preponderance of interventions that are directed at individuals and families. As with data on risk and protective factors, there has been limited work focused on identifying community or societal level protective factors, or interventions. If our goal is to achieve change towards preventing child abuse, further attention to these issues needs to be a priority.

4. INTIMATE PARTNER VIOLENCE

4.1 DEFINITIONS

Intimate partner violence is physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners (Saltzman et al 1999). Further definitions include:

- > **Intimate partners** include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
- > **Physical abuse** includes acts of violence that may result in pain, injury, impairment or disease. This may include hitting, choking or in any way assaulting another person, and also under-/over-medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations, etc) though the differences between accidental injury and abuse can be slight and require expert investigation.
- > **Psychological and emotional abuse** includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, the removal of decision-making powers (in relation to adults), and in relation to a child exposing the child to the physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence result in increased social isolation.
- > **Sexual abuse** includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity that an adult with mental incapacity is unable to understand.

4.2 INCIDENCE AND PREVALENCE

4.2.1 Deaths and hospitalisations

NZ Health Information Service (NZHIS) data indicate that in 2000 and 2001, 27 women (15-64 years) died from homicide (average of 13 per year). In 2003, 283 women aged 15-64 were hospitalised as the result of assault. As the relationship of the perpetrator to the victim is not specified, it is not possible to specify how many of these women were killed or assaulted by partners or ex-partners (NZHIS 2000-01, 2003).

4.2.2 Service-based statistics

Each year police deal with more than 45,000 calls relating to family violence, involving more than 200,000 people. There are significant numbers of repeat calls. In 2002-03 police attended 46,682 incidents of family violence: about 55,000 children were present at these. Police statistics point to approximately 12,000 family violence assaults each year and 4,500 breaches of protection orders (Police submission to the NZPPD 2005).

A paper prepared by the Ministry of Justice provides a summary of the data available within the justice sector that could be used to analyse trends in partner violence. It presents a wide range of service-based statistics including: applications for protection orders; protection orders granted; 'male assaults female' prosecutions; 'male assaults female' convictions; 'male assaults female' recorded offences; and recorded offences coded as family violence. Changes in recorded statistics were analysed to see what could be ascertained about changes in the underlying rates of 'domestic violence'. The analysis showed a slight downward or stable trend in the level of recorded family violence until mid-2002 or early 2003. From 2002-04 there have been sudden increases in recorded offences coded as family violence, but this has been attributed to changes in

police procedures and widespread media coverage that may have encouraged victims to report offences. Conversely the number of applications for protection orders decreased at this time. The fluctuations and contradictions within these data are a common feature of service-based statistics, which are often radically influenced by changes in policy, action and procedure as well as by contextual factors such as media attention on violence (Bartlett 2005).

In 2003 Women's Refuge supported some 13,729 women and 10,053 children towards living free from domestic violence. In 2003 Women's Refuge provided emergency safe-house accommodation to over 5,500 women and children and over 11,000 women and children accessed a Women's Refuge Community Support Worker (National Collective of Independent Women's Refuges Inc, personal communication 2004).

4.2.3 Population-based statistics

There are relatively good estimates of the incidence and prevalence of intimate partner violence (IPV) in New Zealand, as this topic has been the subject of some recent epidemiological studies in general and clinical populations, and is assessed as part of the New Zealand National Survey of Crime Victims (NZNSCV). Prevalence and incidence data are summarised in Table 4.1.

TABLE 4.1: INCIDENCE AND PREVALENCE OF IPV IN NEW ZEALAND				
	POPULATION/SETTING	TYPE OF VIOLENCE	PREVALENCE (LIFETIME)	INCIDENCE (12 MONTHS)
National				
Morris, Reilly, Berry and Ransom (2003)	Nationally representative sample, 15 years and older:	Physical only		
	Ever partnered women		26.4%	3%
	Ever partnered men		18.2%	1.8%
Regional				
Fanslow and Robinson (2004)	Ever partnered women:	Physical and/or sexual		
	Auckland, n=1,356		33%	5.7%
	Waikato, n=1,388		39%	5.4%
Clinical				
Koziol-McLain, Gardiner, Batty, Rameka, Fyfe and Giddings (2004a)	Auckland Emergency Dept n=174	Physical abuse	40%	15%
		Forced sex	20%	3%
		Unsafe	33%	13%
			Total: 44.3%	Total: 21.3%
Koziol-McLain et al (2004a)	Auckland Māori Health Provider Clinic n=109	Physical abuse	68.8%	N/A
		Forced sex	30.3%	
		Unsafe	55.0%	
			Lifetime positive: 78.0%	
Whitehead and Fanslow (2005)	Waikato Abortion Clinic n=62	Physical abuse	43.3%	13.3%
		Sexual abuse	32.2%	8.5%
		Physical or sexual	50.8%	N/A

N/A=Not available

Several points are notable from Table 4.1. The first is that reported rates of IPV vary. Factors contributing to this variance include: the types of violence counted (eg physical only, or physical and/or sexual); the population being considered (eg age range, ethnicity, geographically representative or clinical populations); and methodological

differences in data collection (eg self-administered computer or paper questionnaire versus face-to-face interview). For these reasons, in the absence of a consistent measurement strategy for assessing incidence and prevalence of IPV, it is unlikely that we will be able to come up with one number describing the prevalence of intimate partner violence.

Second, it appears that statistics from clinical samples (ie health care settings) report higher rates than general population studies. This is likely to be the result of greater use of health care services by women who have experienced IPV (Fanslow and Robinson 2004), but may also be compounded by the ethnicity of the populations surveyed. Data from the NZNSCV indicate that Māori women report significantly higher rates of IPV than women of European and other ethnic backgrounds (Morris et al 2003).

Third, there are more limited data available on men's experience of IPV. The NZNSCV is the only large-scale study that has assessed this. Lower lifetime prevalence rates of IPV were reported by ever-partnered men (18.2 percent) than by women (26.4 percent). This violence was more likely to result in serious consequences or fear for women (Morris et al 2003).

International data concur with these findings. Findings from the US National Violence Against Women Survey (telephone surveys with 8,000 women and 8,000 men) indicated that women reported significantly more intimate violence than men, both in the previous 12 months, and over the respondent's lifetime. Women experienced more frequent and longer-lasting victimisation than men, and reported more serious and long-term consequences from the violence than did men, including fear of bodily injury, time lost from work, injuries and use of medical, mental health and justice system services (Tjaden and Thoennes 2000). Kimmel (2002) discusses the methodological reasons why estimates of IPV victimisation reported by men are likely to be overestimated, and IPV victimisation reported by women is likely to be underestimated. Kimmel also looks at the differential use of more severe violence for the purpose of maintaining control (estimated that over 90 percent of this violence is perpetrated by men) (see Box 4.1).

BOX 4.1: GENDER SYMMETRY IN INTIMATE PARTNER VIOLENCE AND RESPONDING TO MALE VICTIMS

One of the most hotly contested issues in the field of intimate partner research is the concept of 'gender symmetry' in perpetration. This concept refers to the idea that women perpetrate intimate partner violence against their partners at rates equal to those perpetrated by men.

In one of the largest studies ever conducted to provide comparable data related to men's and women's experience of violent victimisation, the US National Violence Against Women Survey carried out telephone interviews with nationally representative samples of 8,000 women and 8,000 men (Tjaden and Thoennes 1998). The survey enquired about lifetime experience (prevalence) and experience within the previous 12 months (incidence) of: physical assault (behaviours ranging from slapping to hitting to using a gun); rape (forced vaginal, oral or anal intercourse); and stalking (using a definition that required the victim to feel a high level of fear). Intimate partners were defined as a current or former spouse, cohabiting partner or date. The survey reported the following findings:

- > Women reported significantly more intimate partner violence than men:
 - lifetime prevalence of rape and/or physical assault: 25 percent of women, 8 percent of men
 - previous 12-month incidence of rape and/or physical assault: 1.5 percent of women, 0.9 percent of men.
- > Violence against women is primarily perpetrated by intimate partners. Of women who were raped and/or physically assaulted since age 18, 76 percent of women were victimised by an intimate partner, compared with 18 percent of men.
- > Women were significantly more likely than men to be injured in an assault. Of those who had been raped since age 18, 32 percent of women and 16 percent of men reported that they had been injured in their most recent rape. Of those physically assaulted since age 18, 39 percent of women and 25 percent of men reported being injured during the most recent physical assault.
- > Women were significantly more likely than men to report being stalked:
 - lifetime prevalence: 8 percent of women, 2 percent of men
 - previous 12 months: 1 percent of women, 0.4 percent of men.

Other studies, primarily those that make use of the Conflict Tactics Scale as their measurement tool for assessing partner violence, report that women perpetrate violence against their male partners at rates comparable to the male partner violence inflicted on women (Straus 2001). Use of the Conflict Tactics Scale has been criticised on various grounds including: the focus on measuring 'conflict tactics' (ie strategies used during arguments) rather than violence used for coercive control; the omission of acts of sexual abuse and stalking; the omission of incidents occurring after separation or divorce; and the failure to elicit information about the intensity, context, consequences or meaning of the action (Taft, Hegarty and Flood 2001). When these issues are considered, men emerge as more likely to be the perpetrators of intimate partner violence.

A more detailed critique of the Conflict Tactics Scale, other sources of data and methodological issues associated with the concept of gender symmetry is presented in Kimmel (2002). A review from a New Zealand perspective is available through the Law Commission (2001), which similarly concluded that women are more likely to experience fear and harm than are men when intimate violence occurs.

Does this mean there are no male victims of intimate partner violence? Absolutely not. We need to take seriously the violence that is perpetrated by women against men in intimate relationships, particularly if it causes fear or harm. As Kimmel (2002) argues, compassion is not a zero-sum game, and all victims regardless of their gender need to be offered support, compassion and interventions. At present, however, the data suggest that more women than men experience intimate partner violence, and that the violence inflicted by men against women tends to have more serious consequences (including death and serious injury).

Assessments of coercive control and the degree to which violence engenders fear are likely to prove critical factors in distinguishing men's violence from that perpetrated by women. One seminal study that has explored gender differences in responses to intimate partner violence using psycho-physiological and observation measures concluded: "Only husband violence produces fear in the partners. It is largely this difference that accounts for the unique ability of husbands to use violence as a means

BOX 4.1: GENDER SYMMETRY IN INTIMATE PARTNER VIOLENCE AND RESPONDING TO MALE VICTIMS (continued)

of psychological and social control” (Jacobson, Gottman, Waltz, Rushe, Babcock and Holtzworth-Munroe 1994). Furthermore, descriptions of violent episodes indicated that wives’ violence was reactive to the husband’s violence whereas men’s violence was “in response to a variety of non-violent wife behaviours” (Jacobson et al 1994).

There are also suggestions that women’s violence against men tends to differ in terms of its context. It may be more likely to be in self-defence, or is more likely to be perpetrated as “expressive violence – the way a person might express anger or frustration”. Men’s violence against women may be more likely to be used “instrumentally – to achieve control” (Kimmel 2002). These patterns may equate to the typologies of violence described by Johnson and Ferraro (2000) “common couple violence and intimate terrorism”. Measurement of the degree to which these types of violence exist, and the relative frequency of their use by women versus men, is still being established.

Until we get the definitional and measurement issues more clearly sorted out, there are several cautions for policy-makers and programme planners. While intimate partner violence certainly can be perpetrated by women against men, the existence of this should not be used as an excuse to cut funding for women’s programmes. If male victims are in need of services, efforts should be made to find additional funding for these programmes, but not at the expense of services provided for women.

Other key New Zealand surveys in this area include the Women’s Safety Survey 1996 (Morris 1997), and the Hitting Home Study (Leibrich, Paulin and Ransom 1995). The Women’s Safety Survey was carried out with a sub-sample of participants in the 1996 NZ National Survey of Crime Victims. It provides more detailed information on the extent and types of physical and sexual violence and psychological abuse experienced by women, as well as further information about the circumstances of violence, how women seek help and their experiences in the criminal justice system. The Hitting Home Study was carried out with a nationally representative sample of 2,000 New Zealand men, and a follow-up study with 200 New Zealand men. It describes rates of perpetration of physical, sexual and psychological abuse against female partners, as well as outlining men’s beliefs and values that contribute to violence towards their partners.

4.3 CONSEQUENCES OF INTIMATE PARTNER VIOLENCE

Some of the documented health consequences of intimate partner violence, as summarised by the WHO *World Report on Violence and Health*, are presented in Table 4.2. A number of other reviews were found (Holtzworth-Munroe, Smutzler and Sandin 1997; Coker, Smith, Bethea, King and McKeown 2000; Campbell 2002; Plichta 2004). The reviews document some of the effects of intimate partner violence. Direct effects include mortality, injury, traumatic brain injury, disability, chronic pain and pregnancy and pregnancy outcomes. Indirect effects include poorer general physical health and worse health behaviours such as smoking, drug use and some evidence to suggest worse diets and unhealthy weight control methods (vomiting, as well as use of laxatives). As with child abuse, of note are the associations between intimate partner violence and increased risk of experiencing a variety of chronic health problems (eg hypertension and chest pain, cited in Campbell 2002).

TABLE 4.2: HEALTH CONSEQUENCES OF INTIMATE PARTNER VIOLENCE

Physical	Abdominal/thoracic injuries Bruises and welts Chronic pain syndromes Chronic disease Disability Fibromyalgia Fractures Gastrointestinal disorders Irritable bowel syndrome Lacerations and abrasions Ocular damage Reduced physical functioning
Sexual and Reproductive	Gynaecological disorders Infertility Pelvic inflammatory disease Pregnancy complications/miscarriage Sexual dysfunction Sexually transmitted diseases, including HIV/AIDS Unsafe abortion Unwanted pregnancy
Psychological and Behavioural	Alcohol and drug abuse Depression and anxiety Eating and sleep disorders Feelings of shame and guilt Phobias and panic disorder Physical inactivity Poor self-esteem Post-traumatic stress disorder Psychosomatic disorders Smoking Suicidal behaviour and self-harm
Other Consequences	Reduced ability to obtain and retain paid employment*

Source: *World Report on Violence and Health, Krug et al 2002.*

* *Browne, Salomon and Bassuk 1999; Moe and Bell 2004; Riger, Staggs and Schewe 2004.*

In addition to the documented health consequences, there are social consequences associated with intimate partner violence, including increased use of health care for a wide variety of health problems beyond those related to treatment for injury from IPV (Fanslow and Robinson 2004; Plichta 2004). Other consequences can include impacts on family and friends, such as detrimental effects on children of witnessing violence between their parents (eg depression, developmental problems, aggressive and delinquent behaviour) (Jaffe, Wolfe and Wilson 1990; Fantuzzo and Mohr 1999). There may also be indirect costs to women through loss of employment (Tjaden and Thoennes 2000), harassment at work by partners leading to loss of productivity, and other restricted opportunities (National Research Council 1996). The extent of these social and indirect costs is not known.

4.4 RISK FACTORS FOR INTIMATE PARTNER VIOLENCE

The *World Report on Violence and Health* summarises some of the risk factors associated with male perpetration of violence against intimate partners as set out in Table 4.3. (Krug et al 2002). It is important to note that this list is unlikely to be conclusive, particularly with respect to factors at the community and societal levels. These levels have only recently begun to be the subject of investigation, and important factors may be missing because they have not been investigated. Conversely, some of the factors listed may prove to be correlates, rather than causes of IPV. There are promising indications, however, that community and societal factors can have substantial impact on rates of IPV, as regional and cross-cultural studies have noted variation in rates both within and between countries. In some pre-industrial societies, intimate partner violence is virtually non-existent (Counts, Brown and Campbell 1999). Further exploration of the societal and community factors that contribute to these variations may offer promising directions for future interventions.

TABLE 4.3: FACTORS ASSOCIATED WITH A MAN'S RISK FOR ABUSING HIS PARTNER

INDIVIDUAL FACTORS	RELATIONSHIP FACTORS	COMMUNITY FACTORS	SOCIETAL FACTORS
> Young age	> Marital conflict	> Weak community sanctions against domestic violence	> Traditional gender norms
> Heavy drinking	> Marital instability	> Poverty	> Social norms supportive of violence
> Depression	> Male dominance in the family	> Low social capital	
> Personality disorders	> Economic stress		
> Low academic achievement	> Poor family functioning		
> Low income			
> Witnessing or experiencing violence as a child			

Source: *World Report on Violence and Health, Krug et al 2002.*

4.5 RECOGNISING DIVERSITY IN PERPETRATION OF VIOLENCE AND DIFFERENCES IN COPING TRAJECTORIES FOR 'TARGETS OF VIOLENCE'

There is increasing evidence that perpetrators of intimate partner violence differ in their psychological profiles. For example some exhibit extreme emotional dependence on their partner while others show general anti-social tendencies (Holtzworth-Munroe, Meehan, Herron, Rehman and Stuart 2000; Saunders and Hamill 2003). Even within these categories, there is likely to be variation in the types of violence perpetrated. Some data suggest that highly aggressive anti-social perpetrators may be more likely to become increasingly violent over time, and may be more likely to exhibit other problem behaviours, such as personality disorders and/or drug dependencies. Increasingly, there are suggestions that these variations need to be taken into account in the design and implementation of programmes for perpetrators, and that catering to these differences through an increased diversity of programmes may increase the success rates of these programmes (Bennett, Adams and Williams 2002).

Recognising the need for increasingly diverse responses to perpetrators has been matched by increasing awareness of the complexity and diversity of processes for

victims of abuse. Arriaga and Capezza (2005) have identified some general patterns of coping shown by 'targets' (victims) of violence. They may: experience a sense of betrayal over unexpected violence; try to keep partner happy to avoid an outburst (often engaging in complex mental processes around minimising or denying the violence, or blaming external causes); experience a major event (eg increase in severity of violence, onset of violence against children) that can contribute to labelling themselves as 'abused' and forming intentions to leave. However, it is not known to what extent this process describes everyone, or if there are different trajectories of coping. Until we have better understanding of these processes, and ways of assessing where victims are at, we risk mistiming or offering inappropriate intervention options, depending on where women are in the complex process of becoming free from abuse (described as 'spiralling out' by Hand et al 2002). Increased understanding of these processes also has the potential to assist us to provide interventions that are more likely to interrupt the negative consequences of partner violence. Given the long-term nature of many of these consequences, gaining further understanding of these processes is likely to be a wise investment (Arriaga and Capezza 2005).

The picture of the diversity of perpetrators and targets of IPV is further complicated by concepts of different patterns of violence. The literature in this area is giving increasing attention to patterns described evocatively as 'intimate terrorism' or 'situational couple violence' (Johnson and Ferraro 2000), that are also referred to in international studies as 'wife battering' versus 'wife beating' (Counts et al 1999).

'Intimate terrorism' is described as a form of partner violence involving perpetrators (mostly but not exclusively male) who use any means possible to exert coercive control over their partners. These highly aggressive perpetrators frequently become more violent over time, and often have high levels of co-morbidity (eg personality disorders, drug dependence). 'Situational couple violence', in contrast, is thought to occur in the context of heated arguments, where one or both partners lash out physically, mainly in isolated incidents that are not reflective of general patterns of control. We do not know if (or to what extent) IPV in New Zealand follows these patterns. It has been suggested in other developed countries that intimate terrorism perpetrated by men against women is the predominant type (Campbell 1999). We also know that fear for self and worry for children are common outcomes of IPV perpetrated by men against women (Morris et al 2003). Measures of coercive control and assessments of fear or other distinguishing features may need to be better developed and incorporated into definitions and measurement of IPV, to allow these patterns to be distinguished.

4.6 INTERVENTION AND PREVENTION EFFORTS

As with the area of child abuse, the field of intimate partner violence is characterised by a shortage of interventions that have been rigorously evaluated. The US NRC review (Chalk and King 1998) identified only 34 studies that attempted to evaluate interventions related to intimate partner violence, 19 of which were focused in the area of law enforcement. Thus the evidence on which to base meaningful recommendations about the most effective interventions is limited, particularly as the majority of studies have been carried out in the United States. Further, the interventions discussed in the literature were carried out prior to the work associated with the heterogeneity of perpetrators and victims described in the previous section. As a consequence interventions have tended to be generic rather than specifically tailored to individuals and their situations.

A review of some interventions as summarised from the *World Report on Violence and Health* (Krug et al 2002), are presented in this section. Findings from this review are supplemented by additional key resources relevant to New Zealand.

4.6.1 Health care interventions

Health care interventions in this area have primarily focused on educating health care providers about the extent and consequences of abuse, encouraging routine screening, and drawing up protocols for assessment of risk and referral to external agencies. These procedures have been promoted as good practice (in New Zealand, Fanslow 2002; in the US, American Medical Association 1992; and in the UK, Department of Health 2000).

There is evidence that screening can increase identification of partner violence, and that training and protocols for health care providers can result in improved risk assessment and increased referral to external organisations (Fanslow, Norton, Robinson and Spinola 1998). The Ministry of Health has responded to this information, information about the health consequences of violence, and advocacy pressure by investing in a clinical programme to implement family violence intervention guidelines in the health sector (King 2004). The purpose is to institute early intervention to reduce harm and improve the health and wellbeing of Māori and other New Zealanders who are victims of family violence, on the basis that health professionals are ideally placed to offer early intervention for large numbers of victims of family violence. The importance of institutional support for achieving and maintaining these goals, in the form of policy and procedure, has also been noted (Fanslow, Norton and Robinson 1999; Coben 2002).

The US NRC (Chalk and King 1998) recommended:

That health care and social service providers develop safeguards to strengthen their documentation of abuse and histories of family violence in both individual and group records, whether or not abuse is reported to the authorities. Documentation should be designed to record voluntary disclosures, and to enhance early and co-ordinated interventions. Potential issues that need to be addressed however, include the need to ensure that victims are not stigmatized or discriminated against, and that assurances of privacy and confidentiality are not violated.

Recently a number of comprehensive reviews of health care response to victims of IPV have been undertaken (Ramsey, Richardson, Carter, Davidson and Feder 2002; Nelson, Nygren, McNerney and Klein 2004; US Preventive Services Task Force 2004). They concluded that there is currently insufficient evidence to recommend routine screening for IPV in the health care setting, on the basis that we do not know if screening and brief interventions result in a reduction in assaults for victims of IPV (because these studies have not been carried out). They all cited the need for quality clinical trials.

A three-year randomised controlled trial to assess the effectiveness of a screening and brief intervention protocol for women victims of IPV has just been funded by the NZ Health Research Council, and may begin to answer some of these questions (Koziol-McLain, Fanslow and Davies 2005). If judged to be effective, significant efforts will need to be made to ensure that health care providers have adequate training, skills and support to respond. This is an area that has been described as subject to 'chronic neglect' by the health professionals (US Institute of Medicine 2001).

4.6.2 School-based programmes

Only a small number of studies have focused on the evaluation of programmes for the prevention of dating violence. However, these are some of the best evaluated studies, showing evidence not only of changes in knowledge and attitudes toward relationship violence, but significant reductions in physical and sexual dating violence victimisation and perpetration. These effects were retained four years after the programme (Foshee, Bauman, Ennett, Linder, Benefield and Suchindran 2004) (see Box 4.2). Similar programmes have not been trialled and evaluated in New Zealand, although Auckland Rape Crisis runs an education programme for the prevention of sexual violence called BodySafe that may touch on some similar issues.

BOX 4.2: SAFE DATES PROGRAM

The Safe Dates Program is a school-based intervention for the prevention and reduction of dating violence among adolescents that has been developed, implemented and evaluated in a rural North Carolina county in the US. It consists of a theatre production performed by students, a curriculum component taught by health and physical education teachers (10 x 45-minute sessions), and a poster contest based on curriculum content.

Evaluation of the programme has involved baseline data collection at 10 schools, random allocation of schools to treatment or control conditions, and follow-up at one month and then yearly for four years. Between the year two and year three follow-up, a randomly selected half of the treatment adolescents received a program 'booster', consisting of an 11-page newsletter sent to adolescents' homes and personal contact by a health educator approximately four weeks after the mailout. Process evaluation indicated that high programme fidelity was achieved in treatment schools, and it was reported that 82 percent of adolescents assigned to receive the booster read the newsletter and completed the worksheets it contained.

Results of the evaluation indicated that four years after delivery of the programme, adolescents who participated reported significantly less physical, serious physical and/or sexual dating violence perpetration or victimisation. The booster did not improve the effectiveness of Safe Dates.

Source: Foshee et al 2004.

In New Zealand, the Cool Schools Peer Mediation is a national programme that has been established in primary and secondary schools for 12 years. A description of the programme is provided in the recent evaluation report by Murrow et al (2004). It is described as follows:

the underlying aim is to change the paradigm of the way conflict is handled, thus creating a better learning environment in schools, and links with the Relationship strand of the Health and Physical Education curriculum document. The main goal of the programme is to give students the skills to mediate disputes and conflicts – to empower them to reach a resolution without physical or verbal violence. The programme also aims to reduce the stress on teachers by reducing the number of conflicts that they have to deal with – both inside and outside the classroom. All teachers in the school are trained in the programme, and staff, in turn, teach the mediation skills to their classes. Peer Mediators – older students whose role is to mediate disputes between students – patrol the playground at intervals and lunchtimes, trained and overseen by the Cool Schools Coordinator (a nominated teacher).

A full description of the programme is given in the main body of the report. Evaluation of the Cool Schools conflict resolution programme indicated that it had contributed to reductions in:

- > the number of playground conflicts
- > the number of detentions
- > bullying.

Also observed were: increases in students' leadership and problem-solving skills; changes in teachers' behaviour; and possible flow-on effects to students' academic work (Murrow et al 2004).

Many of these conflict resolution skills are likely to transfer well to intimate relationships. However, not all schools participate in the programme. There may be benefits in building on the programme, by explicitly making the connection for students that positive strategies in conflict resolution can carry beyond the school setting and into intimate relationships.

There are also other promising school-based programmes that might serve as a platform for providing students with useful skills to carry into intimate relationships. The TRAVELLERS programme is a targeted New Zealand school-based early intervention programme designed to enhance protective factors for young people experiencing change, loss and transition and early signs of emotional distress. Results of the pilot study indicated that the programme provided an effective means of identifying and selecting young people who may benefit from participating in an early intervention programme, and achieved a statistically significant reduction in participants' distress. Young people and school personnel both had positive responses to the programme (Dickinson, Coggan and Bennett 2003).

4.6.3 Employer-based programmes

Preventing Violence in the Home runs a programme called DV-Free. This programme works with employers to support and assist staff who are victims of domestic violence through consultation on HR policies, general awareness training for staff and in-depth training for managers (Preventing Violence in the Home 2005). Although it has been evaluated, these results have not been made public.

4.6.4 Gender

Davies et al (2003) reviewed programmes designed to address issues of gender ideology. They reported that programmes such as Rio's Programme H and Western Ontario's Dating Violence Prevention (teaching equitable gender roles) and Mentors in Violence Prevention (encouraging alternative models of masculinity) have met with some success in reducing such behaviour.

4.6.5 Mass media campaigns

Literature on the use of mass media campaigns for preventing violence was reviewed by Davies et al (2003) who concluded that:

Campaigns to raise awareness of the effects and extent of violence against women and children, can contribute to high levels of public and political debate. They are one means of breaking through suppression and denial and can create pressure for legislative change and provision of resources for survivors of abuse. However, there have been campaigns in which pro-violent attitudes have increased in response to messages that centre solely on the dangers of family violence or elder abuse.

Some public awareness campaigns have increased reports of family violence, however, they risk endangering women and children's safety, if requests for help are not responded to promptly and appropriately. Services must be resourced to meet increased demand. This is particularly complex in rural communities where there may be additional issues of physical and socio-cultural isolation, lack of anonymity and a lack of specialised services. Some evaluations have found that members of the public have been encouraged to directly confront perpetrators of violence against women in a way that increases the danger to victims. For the most vulnerable, mass media public education or awareness-raising campaigns alone will be of little help.

Public education seems to be most effective if focused on promoting positive life-enhancing, action-orientated messages, rather than more general prevention messages or those that focus on the negative. Changes are most likely to occur when the target audience perceives immediate and personal benefit to changing their behaviour.

Partnerships with existing television programmes can provide good avenues for modelling and access to information. These programmes can be in various formats. One of the most successful models for the integration of expertise in public education and entertainment is 'edutainment'. One of the best models of this is Soul City in South Africa. There is some interest in using this 'edutainment' model in New Zealand.

Note that a summary of components of good practice in media campaigns is presented in Section 3. These components would also need to be observed in any media campaigns to address intimate partner violence.

4.6.6 Outreach work/advocacy

Advocacy for victims has formed a major component of the non-government response to intimate partner violence. Increasingly, advocates have started to work closely with government agencies. While advocates can work in a wide variety of different settings (eg police stations, legal systems, hospitals), their primary role is usually to focus on the rights and entitlements of victims of violence, providing them with advice and information (Krug et al 2002). Often they provide practical assistance for individuals working through legal or social welfare systems.

In New Zealand, much of this work is carried out under the umbrella of the National Collective of Independent Women's Refuges, but there are other large organisations (eg Auckland's Preventing Violence in the Home, Victim Support) as well as in-house services such as Court Services for Victims. There is some evidence from the UK that these advocacy responses, when combined with an education programme for violent men, can reduce repeated calls to the police (implying that there is a reduced re-occurrence of IPV). There is also evidence they increase women's use of supportive interventions such as shelters, legal advice and support groups (Kelly and Humphreys 2000). In one of the few experimental studies of advocacy work, Sullivan and Bybee (1999) reported that women who were supported by advocates experienced less violence and reported higher quality of life and social support than those who were not.

4.6.7 Legal responses to intimate partner violence

New Zealand followed the international trend of the 1980s and 1990s with the Domestic Violence Act 1995 replacing the Domestic Protection Act 1982. In addition to law reform, responses included training police, court officials and lawyers, and providing special victim advocates to provide assistance through the criminal justice system.

These approaches have been accompanied by programmes for abusers, victims and their children.

The goals of the Domestic Violence Act (1995) are:

To reduce and prevent violence in domestic relationships by:

- > recognising that domestic violence, in all its forms, is unacceptable behaviour
- > ensuring that, where domestic violence occurs, there is effective legal protection for its victims.

The Act aims to achieve the above by:

- > empowering the court to make certain orders to protect victims of domestic violence
- > ensuring that access to the court is as speedy, inexpensive, and simple as is consistent with justice
- > providing, for persons who are victims of domestic violence, appropriate programmes
- > requiring respondents and associated respondents to attend programmes that have the primary objective of stopping or preventing domestic violence
- > providing more effective sanctions and enforcement in the event that a protection order is breached.

A process evaluation of the Act indicated that it is widely supported by those working in the family/domestic violence area from both community and government sectors. They maintain that it is a thorough and progressive piece of legislation providing legal protection and giving priority to safety for victims; and seeking to hold violent offenders accountable while offering steps to help change their violent behaviour (Barwick, Gray and Macky 2000).

One of the provisions under the Domestic Violence Act is programmes for adults and children who have been the victims of domestic violence. These programmes for 'adult protected persons' aim to empower them to:

deal with the effects of domestic violence by informing them, supporting them, and building their self-esteem. Programmes also aim to increase the understanding of protected persons about the nature of domestic violence and its effects, especially in the context of the intergenerational cycle of violence. The programmes should help the protected person to find ways to maximise their own safety. It should inform the protected person about the types of programmes that the respondent might be directed to attend and what the goals of those programmes are (Law Commission 2002).

Evaluation of programmes for 'adult protected persons' indicated that they were effective in teaching women about strategies for keeping themselves and their children safe. However both women who participated in programmes and those who did not reported they experienced a significant reduction in the incidence of abuse. This may in part be influenced by the fact that women who did not participate in the programmes still acquired protection orders, and accessed other informal sources of help such as family and friends (Maxwell, Anderson and Olsen 2001). A review of the effectiveness of these programmes for Māori 'adult protected persons' has also been conducted (Cram, Pihama, Jenkins and Karehana 2002).

The Law Commission has raised concerns that there has been poor uptake of the protected persons programmes, as well as having received concerns that there are not sufficient programmes specifically designed for Māori and Pacific women and children (Law Commission 2002).

There is also provision for programmes for children who have been subjected to or exposed to violence. The Law Commission (2002) states that these programmes:

aim to help children develop their sense of self-esteem and confidence, give them a realistic view about domestic violence, and encourage them to express how they feel about the violence they have experienced in their lives. The programme should teach the children how to keep himself or herself safe in the future and should teach the children conflict resolution and anger-anxiety management skills.

An evaluation of programmes for children has also been conducted (summarised in Section 3.5.6) (Cargo et al 2002).

Another of the goals of the Domestic Violence Act 1995 (together with an amendment to the Guardianship Act 1968) was to enhance the protection and safety of the children involved in family violence. An evaluation of the implementation and impacts of these provisions in relation to the arrangements made for access to children, reported that these provisions have led to a growing use of access arrangements that are safer for both children and custodial parents. However, some children continued to be exposed to violence during access. The evaluation suggested that children's wellbeing would be further protected through improvements to: supervised access services for Māori children; the accessibility of clear and accurate information for parents; the quality of professional services to parents; access to appropriate support services for Māori parents; the courts' access to information about children's safety; the length of time taken to finalise court cases; guidance for informal supervisors; safety outside supervised access centres; and the funding of supervised access services (Chetwin, Knaggs and Young 1999).

4.6.8 Arrest policies and alternative sanctions

Initial studies in the field of intimate partner violence focused on the deterrent effect of arrests in preventing future instances of violence. Data suggested that being arrested for spouse assault deterred perpetrators from assaulting again, in both the US (Sherman and Berk 1984) and New Zealand (Ford 1986). Subsequent attempts to replicate the effects of these programmes with different populations have yielded more mixed results. There are indications that white, employed individuals are more likely to be deterred by arrest than unemployed, non-white individuals (Marciniak 1994, cited in Krug et al 2002). However, while arrest alone is unlikely to be decisive in preventing violence, to *not* arrest where there is clear evidence of a crime is unconscionable; it acts as a signal that the state is effectively pointing to who is an acceptable victim (Robertson 1999a).

Court orders prohibiting an abusive partner from contacting the person they have victimised have been developed in a number of countries, including New Zealand (see above). Evidence of their effectiveness is mixed. One study has reported that protection orders prevented reoccurrence of intimate partner violence for at least one year. Other studies have suggested that the effects of these orders can be undermined if they are not stringently enforced. Still other studies have suggested that protection orders can enhance women's sense of self-esteem, but have little effect on men with serious criminal records (Krug et al 2002).

Some of these concerns, and a number of others in relation to how the judicial system was operating in relation to domestic violence, were articulated by Busch, Robertson and Lapsley (1992) in their study of breaches of protection orders. While many of these concerns were subsequently addressed with the implementation of the Domestic Violence Act 1995, concerns are again being raised about how protection orders are being used in practice (Hann 2004). (See Section 7.1 for further discussion of this issue.)

Alternative sanctions, such as community actions to shame abusers by public shaming and picketing abusers' workplaces or homes, are practised elsewhere. Rajan and Bhatla (2002) provide a description of this practice in India. These have not been utilised in New Zealand. The author is also informed that there may be some Canadian examples of the use of restorative justice to address family violence, but was unable to access literature on these in the time available to prepare this report.

4.6.9 Interventions for batterers

Programmes for perpetrators of intimate partner violence have also been developed. In general, these draw on cognitive behavioural or other psychological principles. Programmes often use a group format and include discussions of gender roles and skill acquisition such as coping with stress and anger, taking responsibility for actions, and showing feelings for others. Different programmes have greater or lesser links in terms of referral patterns from courts, with different levels of sanctions applied for non-compliance in attendance (Krug et al 2002).

A recent meta-analytic review of batterer treatment programmes (Babcock, Green and Robie 2004) reported that overall the programmes evaluated to date were "likely to have minimal impact on reducing recidivism beyond the effect of being arrested". Specifically, the study reported that:

Based on a partner report, treated batterers have a 40 percent chance of being successfully non-violent, and without treatment, they have a 35 percent chance of maintaining non-violence. Thus, there is a five percent increase in the success rate attributable to treatment. To a clinician, this means that a woman is five percent less likely to be re-assaulted by a man who was arrested, sanctioned, and went to a batterers' programme than by a man who was simply arrested and sanctioned.

While such limited effects are disappointing, the authors noted that because of the high prevalence of IPV within the population, even a small additional reduction in the percentage of men who batter may have substantial implications for thousands of women (Babcock et al 2004).

Any improvements in the effectiveness of batterer intervention programmes are likely to require additional efforts to tailor treatments to particular sub-groups of perpetrators, including specific ethnic groups, those with chemical dependency, batterers at different motivational stages, different types of batterers (eg family only, borderline, antisocial/ generally violent). As identified by Babcock et al (2004), effectiveness might also be advanced by efforts to improve attendance and reduce attrition (which may be as high as 50 percent of those referred to the programmes) as well as the inclusion of additional programme components such as emotion-focused work. Their comments on these issues follow:

Taft et al (2001) randomly assigned men to either CBT (cognitive behavioural therapy) or supportive therapy groups, both of which were supplemented with techniques designed to improve treatment retention based on the principles of motivational interviewing (Miller and Rollnick 1991). These techniques consisted of reminder phone calls and supportive handwritten notes after intake and after missed sessions. As a result, the authors report one of the lowest attrition rates in the literature. The core therapies differed dramatically from one another, one being highly structured and the other unstructured, but both revealed strong effect sizes, especially when based on police reports. This study suggests that the small effect sizes due to batterers' interventions may be in part attributable to the client's non-investment and subsequent attrition from the programs. These simple

techniques, which can be an adjunct to any type of program, may increase the client's perception that the program is aware of his absence and is invested in his welfare. Thus, he may be more motivated to complete and actively participate in the program, lowering attrition and recidivism.

The second study to find a large effect size was an evaluation of an intervention called relationship enhancement (Guerney 1977). The goals of relationship enhancement as applied to battering are to help the men develop interpersonal skills that enhance relationships and enable them to stop their use of violence (Waldo 1988). Interventions include role-plays and assigned homework targeted to improve expressive skills, empathy, communication with the partner, and the identification and management of their emotions (see Waldo 1985). This study suggests that more emotion-focused, rather than cognitively focused, interventions may increase the effect size of batterers treatment.

Other recommendations for improving outcomes from these programmes include: continuing for longer rather than shorter periods of time; changing men's attitudes enough that they can discuss their behaviour; and working in tandem with criminal justice systems to rigorously enforce breaches of the programme (Mullender and Burton 2000). Some programmes for perpetrators can actually make abusive situations worse, as perpetrators learn different 'techniques' from others in the group (Robertson 1999b).

In New Zealand there are various ways for men who have perpetrated violence to access programmes, including being directed by the Family Court to attend a programme as part of a condition of a protection order. Through the criminal system, perpetrators may be offered diversions if they agree to voluntarily participate in a non-violence programme, or programme participation may be undertaken as part of sentencing conditions. If the latter, programme participation is usually organised through the Department of Corrections and may be undertaken while the perpetrator is within the prison system, or in the community while on probation. Individuals in the community may also self-refer to some non-violence programmes.

The main purpose of these programmes, as outlined by the Law Commission (2002), is to:

prevent further domestic violence. To this end, the programmes aim to increase the respondents' understanding of the context and effect of domestic violence, particularly the effect it has on victims and children exposed to violence, and the intergenerational effect of domestic violence. The programme also educates participants about the Domestic Violence Act and the consequences that will follow from a breach of a protection order. The course aims to encourage respondents to develop non-violence conflict resolution skills.

It is not known what efforts are being made to assess and enhance the effectiveness of these programmes. However, the Law Commission (2002) noted a concern expressed by programme providers that non-attendees at programmes did not face sufficient risk of prosecution for non-attendance.

The US NRC (Chalk and King 1998) recommended:

The effectiveness of batterer treatment programmes has not been examined through rigorous scientific studies. In the absence of this information, courts need to put into place early warning systems to detect: failure to comply with or complete treatment, or signs of new abuse or retaliation against the victim, and to consider the unintended or inadvertent results of the programme (eg desensitizing effects of an offender recognizing that others also batter).

Development of collaborative strategies among caseworkers, police, prosecutors and judges are recommended as law enforcement interventions that have the potential to improve batterers' compliances with treatment, as well as the certainty of the use of sanctions in addressing domestic violence. These strategies will require extensive co-ordination among diverse sections of the law enforcement and social services community. However, these strategies are considered the most likely to extend the deterrence effects of arrest (noted for employed, married individuals) for different types of batterers in different communities.

TABLE 4.4: INTERVENTION FOR IPV: LEGAL REMEDIES AND JUDICIAL REFORMS

	TARGET POPULATION	INTERVENTION	OUTCOMES
Criminalising abuse	Whole country	Legislate to criminalise physical, sexual and psychological abuse Sometimes supported by special domestic violence courts, training, police, court officials and lawyers, and by providing specialist advisors (advocates) for women	Evaluation of HAIP suggests that criminalisation in the context of a total co-ordinated package can make a very significant contribution to the safety of women
Laws and policies on arrest	Abusers known to the police	Mandatory arrest in cases of IPV	Arrests can deter repeated assaults if the perpetrator is married, employed, or both In some settings, arrests of unemployed and unmarried men led to increased abuse, but only if arrests occurred in isolation from other sanctions Community variables also matter: Men in communities of low unemployment were deterred by arrests, those in areas of high unemployment were more violent after arrests
Alternative sanctions: protection orders	Perpetrators	Court orders that prohibit a man from contacting or abusing his partner Mandate that he leave home	Some studies have reported that protection orders can prevent reoccurrence of violence If arrests for violation of protection orders are rare, this can undermine their effectiveness Protection orders may have little effect on men with serious criminal records

	TARGET POPULATION	INTERVENTION	OUTCOMES
Treatment for abusers	Perpetrators of IPV, court-mandated or self-referred	Group format to discuss gender roles and teach skills, including how to cope with stress and anger, take responsibility for one's actions and show feelings for others	<p>Some studies indicate that men who complete programmes may remain physically non-violent for up to two years</p> <p>However, there are often high drop-out rates for programmes (between one-third and half don't complete), many referred never enrol</p> <p>Better attendance may be supported by action from the justice system for non-attendance (eg issuing arrest warrants)</p> <p>A recent meta-analysis suggested a 5 percent increase in success rate attributable to treatment (an increase in non-violence from 35 percent of men who didn't attend a programme compared to 40 percent of men who did complete*</p>

Source: *World Report on Violence and Health, Krug et al 2002.*
**Babcock et al 2004.*

4.6.10 Co-ordinated community responses

Worldwide, co-ordinated community responses have become more widely implemented as a means of improving monitoring and responses to intimate partner violence. The purposes of these programmes are usually to:

1. exchange information
2. identify and address problems in the provision of services
3. promote good practice through training and drawing up guidelines
4. track cases and carry out institutional audits to assess the practice of different agencies
5. promote community awareness of prevention work (Krug et al 2002).

These have been trialled most extensively where there are links between batterer intervention programmes and criminal justice sector responses. See Box 4.3 for a description of the elements of a model co-ordinated community response.

BOX 4.3: COMPONENTS OF A MODEL COMMUNITY INTERVENTION PROJECT

1. A coordinating council/task force initially comprised of representatives with policy-making authority from battered women's groups, law enforcement, prosecutors' offices, judges, child protection services, batterers' programmes, and other relevant agencies. Once policies are developed, lower level representatives can be assigned to meet regularly to oversee implementation and co-ordination of the response.
2. A written commitment to a common analysis of violence that recognises both the power dynamics of battering and how social institutions sometimes collude in this abuse.
3. Written policies within each agency (eg pro-arrest, pro-prosecution) and agreements for data sharing and co-ordination.
4. A paid coordinator to manage the council and oversee the processing of cases.

Other essential elements:

- > victim's advocates, preferably located outside the justice system, to help battered women negotiate the court system and other social agencies
- > local shelters or safe homes
- > treatment programmes for batterers and court monitoring of compliance
- > training of all relevant staff on the dynamics of abuse and on the procedures and policies they are expected to follow
- > institutional advocacy – active monitoring to ensure that each agency is following its policy and coordinating properly with other actors. Preferably an autonomous advocacy group would undertake this function.

Source: Heise and Chapman 1992.

A UK review has indicated that co-ordination can improve the quality of services offered to women and children (Hague 2000). This is supported by evaluation of the Hamilton Abuse Intervention Project (HAIP), that reported the criminal justice system can work reasonably well to enhance the safety of women and children, particularly in circumstances when there is independent monitoring of the system by community-based women's and children's advocates (Robertson 1999a). However, if poorly implemented, interagency work can also hide the fact that little actually changes. Interventions of this type are also limited by their focus on co-ordinating refuges and the criminal justice system, at the expense of wider involvement with religious communities, schools, etc (Hague 2000).

Shepard (1999) cites evidence that some community intervention projects have reported significant increases in arrests, successful prosecutions, and the numbers of men court-ordered to attend counselling. Robertson and Busch (1993) noted similar changes in the evaluation of the HAIP. However, it is often unclear what effect these collaborative community responses have had on rates of abuse in the community.

Evaluation is considerably complicated by the dynamic and interactive nature of this complex problem, which requires approaches across multiple levels of analysis and multiple service systems (Chalk and King 1998).

As the use of co-ordinated community interventions grows, we may need to develop different evaluation models to track changes at institutional and community levels. Randomised controlled trials are often held up as the 'gold standard' for evaluation but

their fundamental unit of analysis is the individual. Hence they are incompatible with efforts to mobilise and change groups of people using multiple strategies. Alternative evaluation models may offer better insight into the success of these efforts. Possibilities include community intervention trials, where communities are randomised to different conditions, or multiple baseline trials, where interventions are introduced to different communities successively, to see if the effects of the interventions can be replicated.

4.6.11 Community action programmes

An alternate approach to co-ordinated community responses is that of community action programmes – an approach advocated by the Ministry of Health. These are evidence-based, tightly focused programmes aiming at specific outcomes in specific communities of interest. They focus on changing the environment, not the individual. The purpose of this is to make the desired behaviour normative; for example wearing bicycle helmets, fencing swimming pools, not driving after drinking, or not smoking inside.

The Ministry of Health advocates the use of community action programmes because of their perceived benefits in terms of cost-effectiveness – because they work to change the environment, not each individual, they are able to achieve large effects for comparatively small investments. They are also seen to have an ability to tap into existing communities of interest. Community action programmes are viewed as preferable to ‘community development’ efforts that can be too diffuse, and may require the development of new infrastructures, relying on imported funding. In addition community development programmes for violence prevention are thought to be contraindicated, due to the level of commonly held myths and social discomfort about violence (Elvidge, personal communication 2005).

Community action programmes for violence prevention are being developed around the theme of creating a culture of non-violence in all our social institutions – churches, workplaces, schools, sports clubs, marae etc. The goal is to explicitly develop: support for and modelling of respectful relationships; respect for all sectors of society; peaceful conflict resolution; and action to intervene in physical or verbal violence that occurs on their ‘patch’. The Ministry of Health Promoting Youth Non-violence Contract intends to work with the Rugby Football Union, SPARC and other sporting bodies to develop a nationwide commitment to non-violence – developing policy and guidance about violence on and off the field of play, and to educate and train coaches. It has also funded programmes for the development and implementation of violence-free hapū and violence-free marae (NZPPD 2005). These promising approaches require evaluation to determine their effectiveness at achieving their goals.

4.7 SUMMARY AND CONCLUSIONS

This section has documented a wide range of responses to intimate partner violence. It indicated that some school-based dating violence prevention programmes have shown evidence of reducing both victimisation and perpetration of dating violence. Batterer intervention programmes can produce positive changes in a small number of men over and above the effects of arrests and other sanctions. They are also more likely to be effective if linked strongly to criminal justice sanctions. Further improvements in the effectiveness of batterer intervention programmes may be gained by tailoring the programmes to batterer type, stage of readiness to change, or programmes that also address co-morbidity issues such as alcohol and drug use. Davies et al (2003) reviewed promising overseas programmes that addressed gender issues and patriarchal values, and mass media strategies that may show promise.

As with child abuse, though, it is clear from this section that the majority of intervention activities that have been trialled are those directed at individuals. There has been limited work focused on identifying community or societal level risk and protective factors, or interventions.

5. ELDER ABUSE

Elder abuse and neglect has a much shorter scientific history, becoming an area of exploration about 30 years after child abuse started being discussed in the scientific literature. As a consequence, there is less available literature describing the scale and consequences of the problem in New Zealand or internationally. However, concern over the mistreatment of older people needs to be addressed seriously, as the changing demographics of our population mean the older population is increasing.

5.1 DEFINITIONS

US National Academy of Sciences (2002) defines elder abuse as:

- a. intentional actions that cause harm or create a serious risk of harm (whether or not the harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder
- b. failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm.

The WHO Toronto Declaration on Elder Abuse (United Nations 2002) provides a comparable definition:

a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.

Within this framework, various types of violence are included:

- > physical (acts done with the intention of causing physical pain or injury)
- > psychological abuse (acts done with the intention of causing physical pain or injury)
- > sexual assault
- > material exploitation (sometimes called financial abuse), involving the misappropriation of the old person's money or property
- > neglect, or the failure of the carer to meet the needs of a dependent person.

Note that in this category of family violence, financial abuse may be a key component or motivating factor. While it exists as part of the spectrum of violence associated with intimate partner violence in broader conceptual models (eg the Power and Control Wheel), it is only in the area of elder abuse that it is usually included as a core part of the definition of violence. Definitions of elder abuse can also encompass abuse by caregivers who do not have family relationships with the victim, such as abuse within residential care settings.

5.2 INCIDENCE AND PREVALENCE

5.2.1 Deaths and hospitalisations

Data from the NZHIS indicate that seven people (three female, four male) aged 65 years and older were victims of homicide in 2000 and 2001 (average 3.5 per year). In 2003, 38 people (14 female, 24 male) aged 65 years and older were hospitalised as the result of assault. Once again, there is no indication of the relationship between victim and perpetrator in these data.

5.2.2 Service-based statistics

Referrals to Age Concern Elder Abuse and Neglect Services are presented in Table 5.1. As these are service-based statistics, they are not indicative of actual rates of incidence or prevalence in the community. Psychological abuse was the most common type (56 percent of referrals), followed by material/financial abuse (46 percent) then physical abuse (22 percent).

TABLE 5.1: AGE CONCERN ELDER ABUSE AND NEGLECT SERVICE UTILISATION BY YEAR

TYPE OF CONTACT	YEAR (1 JULY–30 JUNE)				
	96/97	97/98	98/99	99/00	00/01
Number of general enquiries	2,506	3,137	3,466	3,071	2,412
Number of new referrals for suspected abuse or neglect	598	706	821	897	975
Number of established cases of abuse or neglect	506	543	506	607	623
Proportion established to be cases of abuse or neglect	85%	77%	62%	68%	64%

Source: Age Concern Elder Abuse and Neglect Services: An Analysis of Referrals, August 2002.

5.2.3 Population-based statistics

There are no population-based or large sample studies documenting the incidence and prevalence of elder abuse in New Zealand. International population-based surveys of elder abuse suggest that between 2 percent and 10 percent of the population aged over 65 years may experience abuse (Thomas 2002). Studies in more developed settings, including national and non-national community-based surveys (for example, in Australia, Canada and the UK), have found the proportion of older persons reported as abused or neglected to range from 3 to 10 percent (United Nations 2002).

Estimates of prevalence will vary according to the definition of the behaviour being measured (eg whether neglect, psychological abuse or financial abuse is assessed), and the age ranges that are considered. In New Zealand most of the statistics are presented in terms of ages 65 years and older, but this age limit may become less appropriate. For example, for Māori it may be more appropriate to look at those aged 55 years and over, given the different age structure of this population. Clinical populations may also have different rates than the general population.

5.3 RISK FACTORS

Etiological data on the factors associated with elder abuse are scant, limited by the small scale of studies that have been conducted, the settings that they have been applied to and the limited scope of the factors that have been explored. Table 5.2 presents some of the possible associations, but further exploration needs to be carried out to identify the strength of these factors, the presence of other factors and the ways in which these interact. Note that the social level factors are proposed, as little empirical research has been carried out to identify these factors (Krug et al 2002).

TABLE 5.2: RISK FACTORS ASSOCIATED WITH ELDER ABUSE			
FACTORS FOR THE VICTIM	FACTORS FOR THE PERPETRATOR	CONTEXTUAL RISK FACTORS	SOCIETAL RISK FACTORS (PROPOSED)
None clearly identified	More likely to be female (most caregivers female)	Financial difficulties	Cultural norms and traditions
	Mental health problems	Family conflict	Ageism
	Substance abuse	Inadequate social support	Sexism
	Inadequate caregiving skills	Social isolation	Culture of violence
	Stress	Overcrowded living arrangements	
	Dependence (eg of the older person on a younger person, younger person on older person, or web of inter-dependency)		

Source: World Report on Violence and Health, Krug et al 2002.

5.4 CONSEQUENCES

There is a paucity of research documenting the physical or other effects associated with elder abuse. The available data are derived primarily from anecdotes, case reports or small case series (Lachs and Pillemer 2004). Some suggested indicators of elder abuse are presented in Table 5.3. The presence of these signs should at least prompt further investigation, particularly among individuals presenting in a clinical health care setting.

TABLE 5.3: INDICATORS OF ELDER ABUSE

INDICATORS RELATING TO THE ELDERLY PERSON				INDICATORS RELATING TO THE CAREGIVER
Physical	Behavioural and emotional	Sexual	Financial	
> Complaints of being physically assaulted	> Change in eating pattern or sleep problems	> Complaints of being sexually assaulted	> Withdrawals of money that are erratic, or not typical of the older person	> Caregiver appears tired or stressed
> Unexplained falls and injuries	> Fear, confusion or air of resignation	> Sexual behaviour that is out of keeping with the older person's usual relationships and previous personality	> Withdrawals of money that are inconsistent with the older person's means	> Caregiver seems excessively concerned or unconcerned
> Burns and bruises in unusual places or of an unusual type	> Passivity, withdrawal or increasing depression	> Unexplained changes in behaviour, such as aggression, withdrawal or self-mutilation	> Changing a will or property title to leave house or assets to 'new friends or relatives'	> Caregiver blames the older person for acts such as incontinence
> Cuts, finger marks or other evidence of physical restraint	> Helplessness, hopelessness or anxiety	> Frequent complaints of abdominal pain, or unexplained vaginal or anal bleeding	> Property is missing	> Caregiver behaves aggressively
> Excessive repeat prescriptions or under usage of medication	> Contradictory statements or other ambivalence not resulting from mental confusion	> Recurrent genital infections, or bruises around the breasts or genital area	> Older person 'can't find' jewellery or personal belongings	> Caregiver treats the older person like a child or in a dehumanised way
> Malnourishment or dehydration without an illness-related cause	> Reluctance to talk openly	> Torn, stained or bloody underclothes	> Suspicious activity on credit card account	> Caregiver has a history of substance abuse or abusing others
> Evidence of inadequate care or poor standards of hygiene	> Avoidance of physical, eye or verbal contact with caregiver		> Lack of amenities, when the older person could afford them	> Caregiver does not want the older person to be interviewed alone
> Person seeks medical attention from a variety of doctors or medical centres	> Older person is isolated by others		> Untreated medical or mental health problems	> Caregiver responds defensively when questioned; may be hostile or evasive
			> Level of care is not commensurate with the older person's income or assets	> Caregiver has been providing care to the older person for a long period of time

Source: *World Report on Violence and Health, Krug et al 2002.*

Death may also be a frequent outcome, with one large longitudinal study reporting that mistreated elders were 3.1 times more likely to die during a three-year period than those not abused, even after controlling for co-morbidity and other factors associated with mortality. At the end of 13 years of follow-up, 9 percent of those mistreated were alive, compared with 41 percent who had not experienced abuse (Lachs, Williams, O'Brien, Pillemer and Charlson, 1998). Abused elders are also at increased risk of being placed in nursing homes (Lachs, Williams, O'Brien and Pillemer 2002).

5.5 INTERVENTIONS

While there is a dearth of information documenting the consequences of elder abuse, what is known should be sufficiently compelling to prompt the development of effective interventions. Unfortunately, however, activity in this regard has been practically non-existent.

In its review of family violence interventions, the US NRC was able to identify two studies of social service-based programmes for the prevention of elder abuse (Chalk and King 1998). In 2002, the US National Academy of Sciences Panel on Elder Abuse concluded:

No efforts have been made to develop, implement, and evaluate interventions based on scientifically grounded hypotheses about the causes of elder abuse, and no systematic research has been conducted to measure and evaluate the effects of existing interventions (National Academy of Sciences 2002).

Although the lack of evidence to guide decision-making on appropriate interventions is disheartening, it is also fair to point out that work in this area can be particularly challenging. Research into geriatric conditions in general is difficult due to: extreme co-morbidity (challenging comparisons of baseline states); the necessity for multi-factorial interventions in order to better address multi-factorial causes, which makes interventions difficult to standardise; and the limited access to frail populations. In this already difficult context, attempts to explore elder abuse are compounded by factors such as: the patient's reluctance to discuss an embarrassing family situation; the wide diversity of activities considered under the label of elder abuse; and difficulty in measuring if or when abuse has occurred, as it may be part of a continuous exposure (Lachs and Pillemer 2004).

As if these challenges were not enough, assessment of and intervention for elder abuse also has levels of complexity associated with determining if the patient has the cognitive functioning and decision-making capacity necessary to make decisions about their future care and safety. For some older people, there is also the issue of the setting for the abuse, as elder abuse within a residential institution may have different dynamics than abuse experienced by community-dwelling older people (Lachs and Pillemer 2004).

While recognising these complexities, and the likely length of time before sufficiently well-designed and executed controlled trials can be carried out, Lachs and Pillemer (2004) have nevertheless developed a framework for suggesting potential interventions in response to different contexts of elder abuse. This framework is reproduced in Table 5.4.

Several distinct themes emerge from this framework. One is the importance of utilising a multi-disciplinary team to respond to violence wherever possible. The second is the need for a diversity of possible treatment options, so there are multiple possibilities to respond to the particular needs of each elder (and their carers). Examples include the need to offer different treatment strategies to: adults with schizophrenia who are abusing a parent; patients with dementia who assault their partner; and cases where intimate partner violence is a longstanding problem for a couple.

TABLE 5.4: CONTEXT-SPECIFIC INTERVENTIONS FOR COMPONENTS OF ELDER ABUSE

CONTEXT OF ELDER ABUSE	POTENTIAL INTERVENTIONS
Abuse potentially related to stress from caring for impaired family member	Respite services Adult day care Carer education programmes (eg on what constitutes abuse) Recruitment of other family, informal, or paid carers to share burden of care Psychotherapy for carer Treatment for depression Social integration of carer to reduce isolation
Violence related to substance abuse or alcohol misuse	Referral to alcohol or drug misuse rehabilitation programmes as appropriate
Violence related to behavioural problems associated with mental health	Treatment referral
Longstanding spousal violence	Marital counselling Support groups Shelter Orders of protection Victim advocacy
Abuse by aggressive dementia patient	Geriatric medical assessment of causes underlying behaviour (eg new or established medical conditions)
Financial exploitation by family members	Guardianship proceeding, power of attorney (transfer of legal authority) Protective services
Financial exploitation by paid carer	Referral to legal services Involvement of law enforcement Protective services

Source: Lachs and Pillemer 2004.

Age Concern is the primary organisation involved in service provision related to elder abuse. At present 15 Age Concern Councils provide Elder Abuse and Neglect (EAN) services in 16 sites throughout New Zealand. EAN services are also contracted to a range of other providers.⁵ These services are part-funded by the Ministry of Social Development through CYF. Their primary activities are to provide a co-ordination and referral service for older people where incidents of elder abuse and neglect are reported and managed, and to provide education and training in elder abuse and neglect prevention for carers, those who work with older people and the wider community (Age Concern NZ 2002).

Elder Abuse and Neglect Prevention (EANP) services also provide co-ordination of intervention as well as prevention work in the form of education and training for carers,

⁵ Other contracted providers of EAN services are: Tui Ora Ltd, Te Oranga Kaumātua Kuia Services Trust, Buller REAP, Presbyterian Support South Canterbury, Presbyterian Support Northern, Presbyterian Support Central and TOA Pacific.

people who work with older people and the wider community. The 29 Age Concern Councils also carry out work promoting positive ageing, and dispelling the myths of ageing. Age Concern also has a community education project related to prevention of financial abuse through education about use of enduring powers of attorney.

5.6 SUMMARY AND CONCLUSIONS

The predominant message from this review of the literature on elder abuse is that there has been an extremely limited amount of research directed at determining the extent and consequences of elder abuse, and even less effort directed towards developing and evaluating effective interventions. What is known internationally, however, suggests that the scale of the problem is sufficiently extensive, and the consequences suitably severe (ie premature death and greater likelihood of placement in nursing homes) to justify further support for existing interventions, and the development and evaluation of new efforts to address the problem.

6. CROSS-CUTTING ISSUES

6.1 CO-OCCURRENCE OF CHILD ABUSE AND PARTNER ABUSE

Just as different types of violence (physical, sexual and psychological) do not tend to occur in isolation from each other, it is increasingly recognised that child abuse and intimate partner violence may co-occur within families, as we better understand the extent and mechanisms by which these types of violence interact.

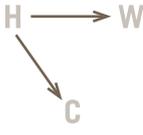
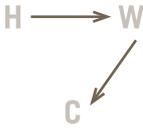
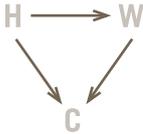
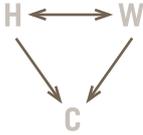
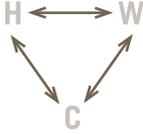
A review of 31 studies assessing the co-occurrence of physical child abuse and intimate partner violence reported the following (Appel and Holden 1998):

- > six percent co-occurrence (range 5.6-11 percent) co-occurrence in representative community samples
- > forty percent median co-occurrence (range 20-100 percent) in clinical samples of either battered women or physically abused children.

Thus data are clear that in homes where IPV occurs, children are at risk of being physically abused. However, some additional issues require consideration. For example, why were there such widely divergent rates of co-occurrence in the clinical samples? Methodological differences were partly responsible (eg in the child criteria used to indicate abuse; whether the referent period for abuse was the past year or ever). However there are also questions related to whether the perpetrator of the abuse was the mother or father.

Some studies suggest that where partner abuse and child abuse co-exist, the violent partner is most likely to be the perpetrator of child abuse and that this association is stronger for males than females (Ross 1996). However, Appel and Holden (1998) identify five possible models by which child abuse and partner violence may co-occur within families (Figure 6.1). The available data from clinical samples did not clearly support one model over the other, and data at the community level were not available.

FIGURE 6.1: MODELS OF CO-OCCURRING SPOUSE AND PHYSICAL CHILD ABUSE

MODEL	EMPIRICAL SUPPORT
<p>SINGLE PERPETRATOR</p>  <pre> graph TD H --> W H --> C </pre>	<p>Hilton (1992) Bowker et al (1988) Suh & Abel (1990)</p>
<p>SEQUENTIAL PERPETRATOR</p>  <pre> graph TD H --> W W --> C </pre>	<p>Kruttschnitt & Dornfeld (1992)</p>
<p>DUAL PERPETRATOR</p>  <pre> graph TD H --> C W --> C </pre>	<p>Walker (1984) Jouriles & LeCompte (1991)</p>
<p>MARITAL VIOLENCE</p>  <pre> graph TD H <--> W H --> C W --> C </pre>	<p>Simons et al (1995) Moore & Pepler (1998)</p>
<p>FAMILY DYSFUNCTION</p>  <pre> graph TD H <--> W H <--> C W <--> C </pre>	<p>Gelles & Straus (1988) Jouriles & Norwood (1995) O'Keefe (1994)</p>

H = husband; W = wife; C = child.

Source: Appel and Holden 1998.

Determining which model is most common has implications for the type of treatment and intervention required. In three of the models (single perpetrator, sequential perpetrator, dual perpetrator) it appears that substantial reductions in the level of violence directed at children could be reduced if the violence by the male partner could be adequately addressed. This is consistent with the experience reported by innovative child welfare services in Australia, who report that there is over 90 percent co-occurrence of child abuse and IPV among their clientele; yet in the majority of cases once the partner violence has been addressed, the children were also safe (Burke, personal communication 2001). However, if data were to indicate that alternate models of co-occurrence are highly prevalent (eg involving joint marital violence, or generalised

family dysfunction, in which the children are also involved in violence), alternative treatment and intervention strategies may be required. Until we know to what extent (or if) these different models apply, we are limited in our ability to generate estimates of the resources that should be devoted to each one. Determining the relative prevalence of these models will, however, be challenging to disentangle, and will require careful consideration of conflict-driven versus control-oriented violence as well as gender considerations (Kimmel 2002).

6.2 ELDER ABUSE AND OTHER TYPES OF FAMILY VIOLENCE

There are some suggestions that children who were abused by their parents may in turn become abusers as their parents age and become more vulnerable. However, there are insufficient epidemiological data to determine the extent of this. Similarly, although there are anecdotal reports of intimate partner violence that continues into the older age groups, or violence that is perpetrated in seeming retribution for earlier victimisation, we do not have data on the extent to which this occurs.

6.3 OTHER CONSEQUENCES: ECONOMIC COSTS

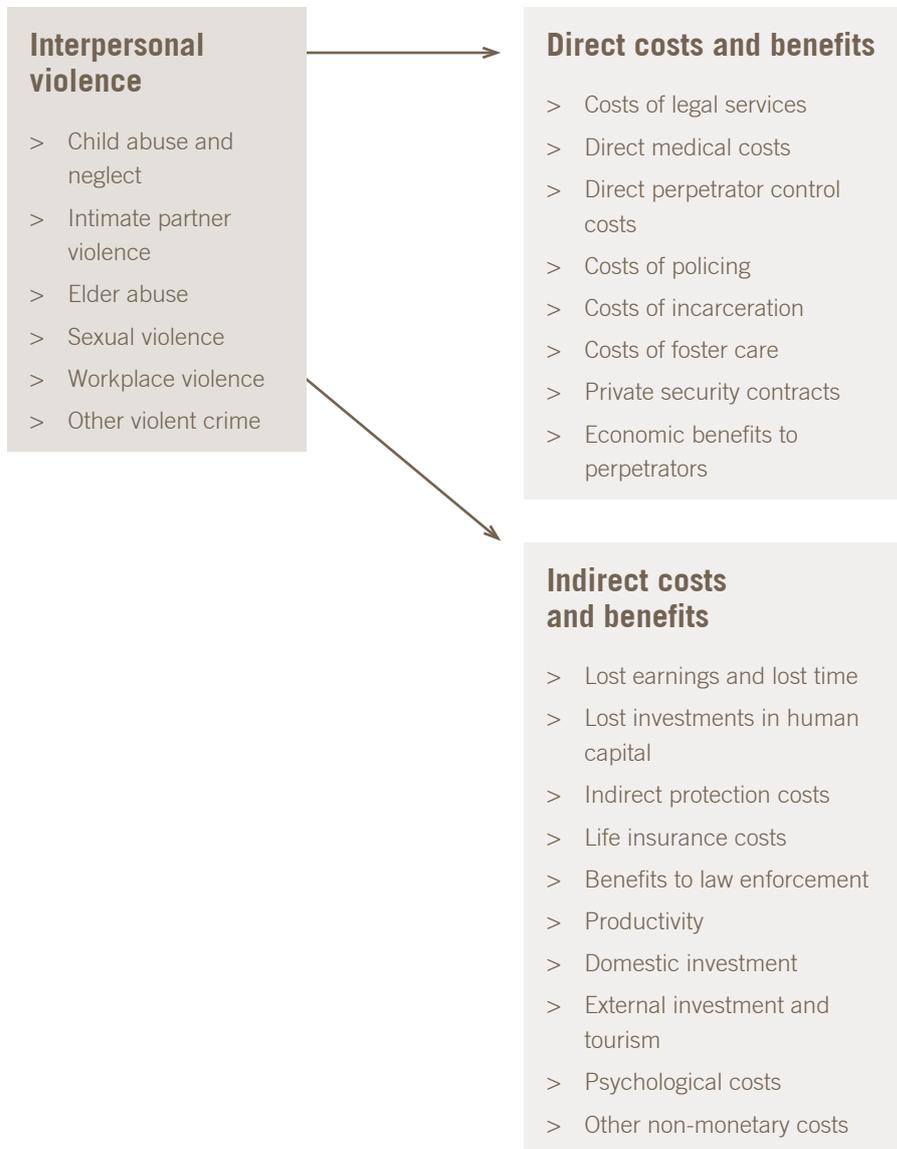
The economic costs of family violence are high. A 1994 study on the economic costs of family violence (including child abuse and intimate partner violence), estimated costs of between \$1.2 and \$5.8 billion annually in direct and indirect costs to individuals and the Government. One of the largest contributors to the cost was the 'income foregone' (lost income) components for both victims and perpetrators (Snively 1994). Innovative in its time, this study is limited now by its age, and has been the subject of criticism on the basis of its estimates of prevalence and of costs. However, it remains a baseline indicator of the magnitude of the costs to individuals, families and society. Should the study be repeated, it is clear that the minimum estimates of the economic costs would be exceeded, as we now have better information on prevalence (higher estimates than those used by Snively), and more information on the far-reaching health, employment and other social consequences of family violence.

In addition, we have better insights into the cost of failing to prevent violence, with estimated costs associated with homicide put at a cost per homicide of \$829,000 (Fanslow, Coggan and Norton 1997). A 2001 study of the costs of child sexual abuse in New Zealand estimated that when health, mental health and legal costs were combined with losses in earnings and the loss of a person's life potential, the overall cost to the country was \$2.4 billion per year (Julich 2001). There are also unanticipated costs to the country associated with 'after the fact' mechanisms of response such as commissions of inquiry into high-profile deaths.

The WHO has provided a framework for conceptualising costs associated with interpersonal violence, set out in Figure 6.2 (Waters, Hyder, Rajkotia, Basu, Behwinkel and Butchart 2004). Investigators in Australia have reviewed methods for seeking to assess the economic dimensions of family and interpersonal violence (Laing and Bobic 2002).

Efforts to assess costs are useful to the extent that they encourage us to invest in prevention. It is clear from these reviews, however, that while the direct and indirect costs of family violence are enormous, they still do not capture the intangible costs associated with pain, fear, suffering and damaged life opportunities.

FIGURE 6.2: DIRECT AND INDIRECT COSTS AND BENEFITS ASSOCIATED WITH INTERPERSONAL VIOLENCE



Source: Waters et al 2004.

6.4 SUMMARY: WHAT HAVE WE LEARNED?

Significant numbers of people experience and are adversely affected by family violence. Exact incidence and prevalence figures are difficult to come by due to inconsistencies in definitions, case identification and recording. Increased ability to measure incidence and prevalence of family violence is important if we are to be able to monitor changes over time. Increased knowledge of the profile and distribution of types of violence would help guide allocation of resource.

Consequences of family violence include economic, social and health costs to the individual, families, communities and society. Family violence may underpin many of the health and social problems we are trying to address through other mechanisms.

Pathways in The range of influences that contribute to people becoming perpetrators are complex and multi-faceted.

More research attention needs to be focused on determining factors that contribute to individuals becoming perpetrators, particularly factors at the community or societal level. Identification of protective factors would also be of considerable benefit.

Pathways out The pathways that victims of family violence take to recover and become survivors are also complex, as is rehabilitation of perpetrators.

Improved knowledge of the pathways or trajectories that victims take in coping with or responding to family violence would help us target interventions more effectively. Similarly, improved knowledge of types of batterers and the circumstances that facilitate and support their behaviour change would be beneficial.

More investment needs to be made in determining institutional, community and societal level factors that influence family violence, as well as the mechanisms for influencing these.

A small number of prevention efforts have demonstrated that they can produce significant reduction in child abuse (eg home visitation for at-risk parents) or intimate partner violence (eg school-based dating violence prevention programmes).

Further effort needs to be directed at identifying the critical components of these programmes so that they can be effectively replicated. Efforts to refine these programmes, and identify new ones may benefit from improved questions. 'What works?' is no longer a useful question. Instead, we need to ask, 'What works, for whom, under what conditions, and for how long?'

Community-based interventions that involve multiple sectors of the community (the community saturation model) show promise and are worthy of further exploration.

7. WHERE TO NEXT? LET'S DECIDE WHAT OUR GOALS ARE

To get anywhere, it pays to be clear on the destination. In this case, it means being clear on what we are seeking to achieve. The New Zealand Parliamentarians' Group on Population and Development (NZPPD) released their report *Creating a Culture of Non-Violence* in June 2005, summarising submissions from an Open Hearing on the elimination of violence against women and children. The review of government activities in this area, presented as an appendix to their report, highlights one of the inherent tensions in the goals that we are setting for ourselves.

This tension requires explicit recognition: we are trying to create a culture of non-violence, but the majority of our actions have focused on responding to perpetrators, victims and their children who are known/identified to the system. While these service-based responses are important, they come under the heading of 'secondary or tertiary prevention'⁶, and are unlikely to lower the overall incidence of violence. Similarly, we have developed legislation that outlines what is outside the bounds of acceptable behaviour. This legislative framework is crucial for developing a responsive strategy to known cases of intimate partner violence, but in the absence of clear evidence that legislation is a deterrent, we have to be clear that its role is primarily one of setting of 'minimal standards' of behaviour – that is, zero tolerance for violence. (See Zorn 1999 for an additional discussion of the role of legislation in these issues.)

However, if the true goal is to develop a 'culture of non-violence', then we need to start talking about what this would look like. This is likely to mean that we have to start discussing and identifying what a culture of non-violence encompasses, and identifying the component skills, resources and institutional and cultural supports that will allow us to acquire and enact this. Rather than just telling people what we don't want them to do, or what behaviour is unacceptable (seldom an effective strategy for behaviour change), we may find that if we are clear about what healthy non-violent relationships look like, why we want them and what the 'goodies' are that go along with them, for both victims and perpetrators, then this becomes a goal that people are interested in achieving.

An example:

A recent anthropological study of young adult New Zealanders sought to identify their perceptions of healthy and unhealthy intimate heterosexual relationships, and factors that influenced these. The study reported that many young people had clear conceptions of what a healthy relationship looked like (involving trust, empathy, communication, intimacy and balance). When asked about factors that influenced their knowledge of intimate relationships, answers could be grouped according to individual experience, learning from family and friends, and popular culture transmitted through media such as movies, books and magazines. What informants identified, however, was that much of their learning on how to 'do' healthy relationships came from individual experience or informal observations of friends and family, and that when they encountered difficulty with relationships, they tended to fall back more on 'popular culture' images of how these situations should be handled (McKenzie 2004).

This study identifies some fascinating issues. The majority of people interviewed shared a common vision of a healthy, well-functioning relationship, but the component skills and resources needed to support such a relationship were often learned in an ad hoc way (or developed implicitly, rather than explicitly). Skills and resources for managing situations of tension or conflict seemed particularly poorly developed, and were reliant

⁶ Primary prevention – approaches that aim to prevent violence before it occurs.

Secondary prevention – approaches that focus on the more immediate responses to violence, such as pre-hospital care, emergency services or treatment for immediate medical needs.

Tertiary prevention – approaches that focus on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempts to lessen trauma or reduce the long-term disability associated with violence.

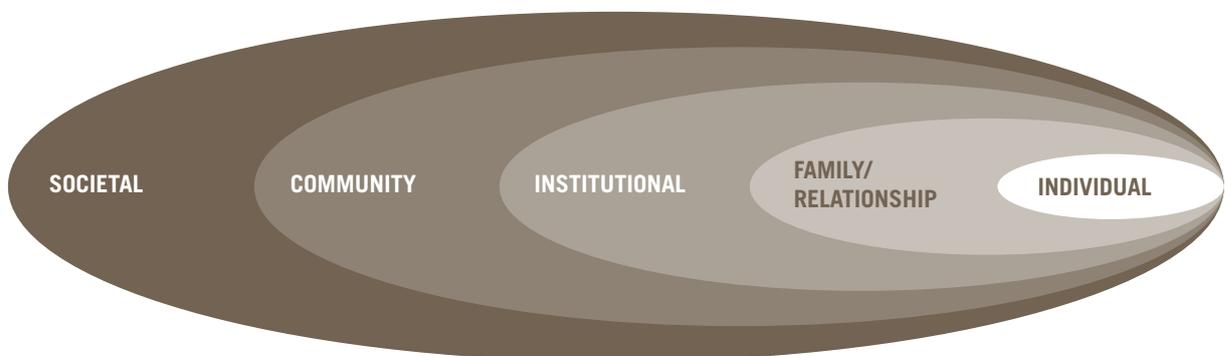
on models that have been developed for different purposes such as creating dramatic tension in media formats.

If we are trying to develop a culture of non-violence, are these things we should be leaving to chance? Or is this an area that we need to start an explicit dialogue on: talking about what healthy relationships look like and what they don't include; costs and benefits of having healthy versus unhealthy relationships for both victims and perpetrators; and identifying the skills and supports needed to achieve them. If we can agree on what we want, then we can start looking at which sectors of our society are best positioned to help us achieve which parts of these goals, because we need everybody to be involved. The next sections outline how.

7.1 A THEORETICAL FRAMEWORK FOR VIOLENCE PREVENTION

As the complexity of factors contributing to the occurrence of violence has become clear, there have been efforts to develop frameworks for conceptualising, identifying and addressing these factors. The ecological model shown in Figure 7.1 is currently one of the most common frameworks used to represent the levels of influence that contribute to violent behaviour.⁷ The model allows representation and exploration of the relationship between individual and contextual factors and considers violence as the product of multiple levels of influence on behaviour. Further details of the different levels are provided in Box 7.1.

FIGURE 7.1:



Source: World Report on Violence and Health, Krug et al 2002.

In addition to providing a tool for conceptualising risk and protective factors at different levels and the interactive nature of these factors, this framework is useful for conceptualising the types of interventions that have been tried. Analysis on this basis indicates that the majority of family violence interventions have been directed at the individual level, and/or the family/relationship level (eg refuge support, child protective services, EAN services). More limited forays have been made into interventions that seek to address links across these levels (eg co-ordinated community response programmes that incorporate services for victims and perpetrators through co-ordinated action with various institutions). With the exception of advances in legislation, action at the societal level has been sporadic and unsustainable, such as short-term media campaigns.

⁷ For a summary of other theoretical perspectives related to violence, the reader is referred to Davies et al 2003.

Further complicating the picture is that interventions are not only targeted at different ecological levels, but also scattered across different sectors, with some administered through justice, others in health, still others in social services. This makes it harder to get an overarching picture of the interventions that have been attempted, and the gaps that remain. Yet it has been recognised for some time that co-ordinated community responses to violence require input from all sectors, and that each sector has unique contributions to make (see Co-ordinated Community Action Model, Figure 7.2).

BOX 7.1: LEVELS OF THE ECOLOGICAL MODEL (ADAPTED FROM KRUG ET AL 2002)

Individual Biological and personal history factors, including biological and demographic factors, factors such as impulsivity, low educational attainment, substance abuse and prior history of aggression and abuse.

Relationship Proximal social relationships, for example, relations with peers, intimate partners and family members. Interacting on an almost daily basis or sharing a common domicile with an abuser may increase the opportunity for violent encounters. Individuals in continuing relationships may increase the likelihood of repeat victimisation.

Institutional This level has been added due to increasing recognition of the importance of institutions and institutional practice in influencing behaviour. This level is often not pictured in representations of the model.

Community The community contexts in which social relationships are embedded – such as schools, workplaces and neighbourhoods. This level seeks to identify the characteristics of these settings that are associated with being victims or perpetrators of violence. These include for example: high levels of residential mobility (where people do not stay for a long time in a particular dwelling, but move many times); heterogeneity (highly diverse population, with little of the social ‘glue’ that binds communities together); high population density; communities with problems such as drug trafficking; high levels of unemployment; and widespread social isolation (people not knowing their neighbours or having no involvement in the local community). Opportunities for violence are greater in some community contexts than others – for instance, in areas of poverty or physical deterioration, or where there are few institutional supports.

Societal Larger societal factors that influence rates of violence. These include, for example: cultural norms that support violence as an acceptable way to resolve conflicts; norms that give priority to parental rights over child welfare; and norms that entrench male dominance over women and children. Larger societal factors also include the health, educational, economic and social policies that maintain high levels of economic or social inequality between groups in society.

There are complex linkages between these levels. The Ecological Model highlights the multiple causes of violence and the interaction of risk factors operating within the family and broader community, social, cultural and economic contexts.

The model also shows how violence may be caused by different factors at different stages of life. While some risk factors may be unique to a particular type of violence, more commonly various types of violence share a number of risk factors. Prevailing cultural norms, poverty, social isolation and factors such as alcohol abuse, substance abuse and access to firearms are risk factors for more than one type of violence. As a result, it is not unusual for some individuals at risk to experience more than one type

of violence. The links between violence and the interaction between individual factors and the broader social, cultural and economic contexts suggest that addressing risk factors across multiple levels of the ecological model may contribute to decreases in more than one type of violence.

Adapted from: World Report on Violence and Health, Krug et al 2002.

FIGURE 7.2:

CO-ORDINATED COMMUNITY ACTION MODEL

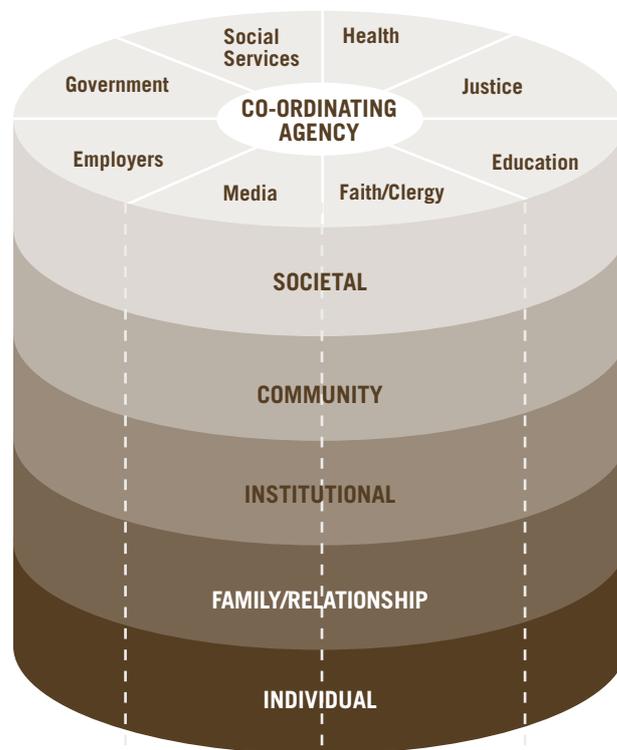
A demonstration of ways communities can accountably act to support victims of domestic violence.



This model was developed by the Domestic Violence Institute of Michigan, based on the Domestic Abuse Intervention Project Wheel format.

How can we use these conceptual models to further our understanding of what has been done, what is planned and what needs to be addressed in the future? One approach is to combine the ecological model and co-ordinated community response model, as has been done in Figure 7.3.⁸ This indicates that all sectors have influence and responsibilities across all ecological levels, as well as interactions or links with other sectors. It suggests that achieving a society where family violence is unacceptable is only likely when a majority (or at least a critical mass) of sectors, operating across most of the ecological levels, are functioning in such a way that violence is not condoned or supported, and/or where healthy relationships are actively promoted.

FIGURE 7.3:

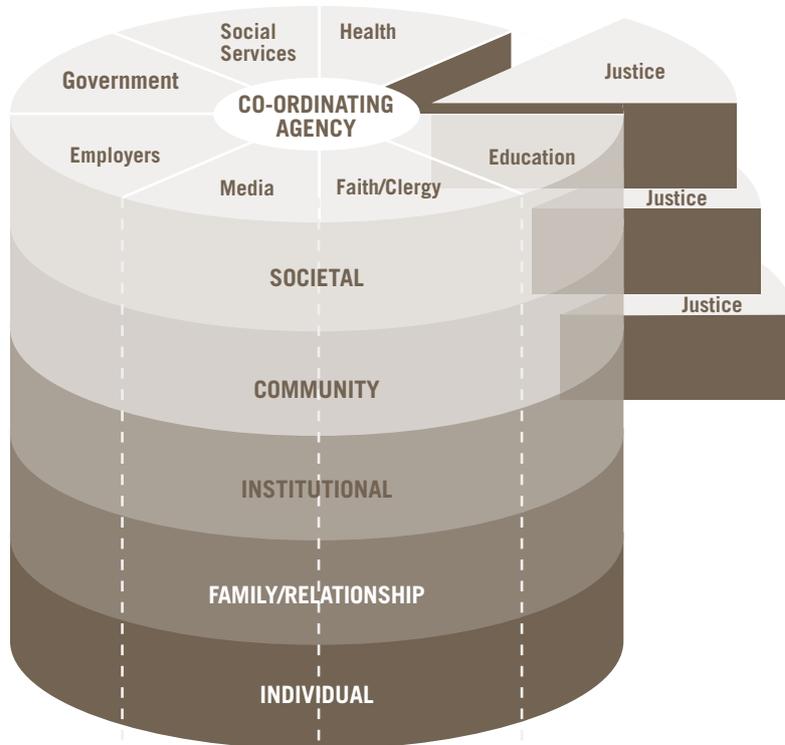


To illustrate the utility of this model, the following section presents an analysis of New Zealand’s efforts to respond to intimate partner violence over the past three decades.

The justice sector response to intimate partner violence has been one of the most well-developed over the past 20 years (Figure 7.4). Some societal level response has been achieved through the implementation of the Domestic Violence Act 1995. Community level response has been achieved in some localities, through intensive effort (eg Hamilton Abuse Intervention Project, WAVES), and links with institutional change (eg police arrest policy in cases of domestic violence, the establishment of protection orders and court services for victims). The justice sector has also worked at the individual level, through the provision of programmes for perpetrators and victims of violence, and their children. These initiatives, developed through the collective work of government, justice sector staff and NGO groups over many years, are recognised as significant advances that promote a vital framework for response.

⁸ Davies et al (2002).

FIGURE 7.4:



Yet despite these advances, there are concerns that implementation of these measures is not always creating the optimal result. In a study of the implementation of protection orders Hann (2004) suggested that the recent decrease in the number of applications for protection orders may be attributed to factors such as: victims' lack of confidence in the system; the increased numbers of protection order applications being put 'on notice'⁹; and the increased burden of proof on victims of violence. Hann also suggests that the safety of some women has been compromised by an increasing variation in the ways in which protection orders are being put into practice. These include increased numbers of 'without notice' applications being put 'on notice' by judges, and judges, lawyers, police and the Legal Services Agency seeming to be more disbelieving of women's realities of violence and requiring much more proof of violence.

One way of interpreting these results is to look at the individual level within the justice sector, and the degree to which individuals within the system are operating in ways that are consistent with the overall framework. It is possible that the relationship level is also strongly implicated in this process, as individuals interact with those around them to create understandings that either support the major aims of the system (increasing victim safety and offender accountability), or create alternative conceptualisations that counter these aims. Examples of these alternatives are statements by judges, lawyers, MPs and other groups that women are using the Domestic Violence Act as 'a sword not a shield' (cited in Hann 2004).

⁹ Where a respondent is notified that an application for a protection order has been filed against them, after which the respondent can notify the court that they wish to file a defence. In contrast, 'without notice' applications allow judges to issue temporary protection orders without prior notification to the respondent, who then has three months to tell the court they wish to file a defence. If no notification is filed, the temporary order becomes permanent after three months. See Hann 2004 for a fuller description.

Other responses to intimate partner violence have been initiated within New Zealand. These include health sector responses at the individual level (eg training programmes and policies directed at encouraging health care providers to screen, carry out risk assessment and refer victims of IPV) and the institutional level (implementation of policies and procedures with health care settings). Media responses at the societal level have also occurred (eg Reach Out Campaign in 1998), but have not been sustained. A small number of programmes with employers have also been initiated, focused on working with employers to support and assist staff who are victims of domestic violence through consultation on HR policies, general awareness training for staff and in-depth training for managers (Preventing Violence in the Home 2005).

Government has undertaken initiatives at the societal level such as the development of legislation, strategy documents and implementation plans. The social services sector has recently started initiatives at the institutional level, with the Family Violence Funding Circuit Breaker Programme, which seeks to improve co-ordination and alignment of government funding processes. This sector is also involved at the individual level, with the Work and Income Family Violence Intervention Programme designed to help case managers identify and respond appropriately to victims and perpetrators of family violence (Ministry of Social Development 2005b).

To date, little activity regarding religious/faith community involvement in intervention or prevention of intimate partner violence has taken place, although there was some discussion of it in the 1990s. In general, the education sector has not engaged strongly with this topic, although there are model programmes dealing with bullying and conflict resolution that would make good platforms for extension, and international models that have been evaluated and shown to be effective at preventing dating violence.

Mapping these responses on an overall model gives us the opportunity to see that, although much intervention and a small amount of prevention has been attempted, the limited number of sectors that have been engaged and the small number of ecological levels that have been influenced are likely to be insufficient to create lasting change.

This model may also help explain some of the evaluation findings of isolated programmes. For example, batterer intervention programmes have been noted for their limited success. Viewed from the context of the programme (and the dedicated people who may run it), this does not make much sense. But when viewed from the perspective that the man is receiving messages from the whole social system, perhaps the more surprising finding is that any perpetrators change at all. After all, his participation in the programme may have altered only one (or at most several) components of the overall picture.

Further effort needs to be directed at ensuring consistency of response within sectors across ecological levels, and engaging new sectors where responses have been limited. Consistency is needed on a philosophical as well as practical level. One of the strengths of co-ordinated community intervention projects is that they are built on a shared analysis of violence – that it is a heavily gendered affair, an abuse of people's rights, serves particular functions (cementing the power and control of the perpetrator) and is largely resident in the culture rather than the individual. This minimises the risk of unhelpful interventions, which endanger or blame victims.

Clarifying the roles of each sector means that each will be able to focus their resources. For example, in this model, the justice sector would be able to concentrate on law enforcement and administration of sanctions, civil responses and other programmes as appropriate. This is appropriate, and quite feasible, if workers in this sector hold the belief that the other needs of the clients they are serving are being adequately met by other sectors, such as social services.

This model would look different for New Zealand's responses to child abuse and elder abuse. Ultimately, the goal would be to overlay these models to discover where we can get maximum value, reduce duplication of effort, or find new avenues to develop prevention and intervention activities across all areas of family violence.

7.2 WORKING WITH DIFFERENT SECTORS ACROSS ECOLOGICAL LEVELS

If we use this model as a conceptual tool to guide our future responses to family violence, one of the questions that surfaces quickly is 'how do we engage each sector?' The answer, of course, differs according to what degree of response each sector has already developed. Given the complexity of the system we are dealing with, the temporal sequence of steps to achieve sector engagement is also likely to vary, with some steps occurring simultaneously, occurring in a different order, and/or with initiatives needing to be re-launched or re-thought in response to emerging information. While recognising these complexities, it is still possible to suggest some fundamental steps that each sector is likely to need to engage in at some stage. These steps are described below, with reference to some of the ways each step has been taken in different sectors. The steps roughly correlate with working through the ecological levels, beginning with the societal level.

Step 1: Defining response to violence as part of the sector's core business

Identification and articulation of the sector's appropriate response to violence is an important first step, with two critical components:

1. identification and clear articulation of the role of the sector
2. relevance.

The first can seem basic, but it often isn't. The sectors represented in the conceptual model are broad, and each is made up of diverse groups, sub-systems and individuals who can hold widely divergent views on what they are doing and why. As a consequence, articulation of the fundamental principle underlying each sector's 'core business' requires careful consideration. There may also be differences between how these principles are identified and articulated between sectors that are largely state controlled, and sectors in the private sphere such as media, employers and faith communities.

The relevance of violence to each sector must also be explicitly stated. As evidence of the health impact of family violence has mounted, the health sector has become far more interested in developing responses to it. As information has emerged on how intimate partner violence reduces productivity within the workplace, there has been more scope to gain the ear of employers and enlist their collaboration in developing workplace procedures that support the safety of victims.

The justice sector clearly has a well thought out framework for its response to intimate partner violence, articulated through the Domestic Violence Act. As a consequence of establishing this framework, flow-on procedural changes within the justice system were developed (see below). However, a prerequisite for these initiatives was ensuring that individuals within the system accepted the importance of addressing intimate partner violence as part of their job. Similarly, today's police policies and practices would have been unthinkable several decades ago, when the police worked from the premise that their role in response to 'domestics' was to mediate but not arrest. And not until judges decided that they should provide protection for victims of partner abuse could the mechanisms to achieve this be developed.

The health sector has gone through a similar transition, and has made conscious efforts to identify appropriate responses to intimate partner violence that are consistent with the core principles of the sector. These are: beneficence – to do good; and non-maleficence – to do no harm (Council on Ethical and Judicial Affairs, American Medical Association 1992). Once the issue of intimate partner violence was seen as relevant and ‘in scope’ then practitioners and others have worked to develop protocols and other institutional practices to respond.

Step 2: Identifying and developing appropriate procedural responses (pilot programmes)

Once addressing violence is defined as ‘in scope’ at a sector level, and seen as a relevant sphere of action, thoughts move to considering what to do about it. This usually amounts to developing procedural responses or guidelines, often at the institutional level. If we are lucky these can be developed with reference to the experience of others, drawing on innovative responses created elsewhere, either documented in the research literature, or through access to best practice guidelines developed by others. However, as seen in the review section of this document, often this evidence is scanty or provides mixed results, is tied to a specific programme in one setting (eg home visitation programmes by one research lab in New York State) or is lacking altogether (eg guidelines for reporting family violence in the media). In cases where no response has been developed, we will be starting from the basics of what we think will work, based on our best understanding of what we are trying to achieve, and what tools we have available in the sector.

Step 3: Training and implementation

Once guidelines and protocols have been developed, and preferably evaluated, sectors often move on to training workers. This training generally encompasses explicit identification of the issues identified in Step 1, why the sector has an important role in responding to family violence and why it is relevant to the sector to do so. Once the workers have bought in to the framework of why it is important to incorporate this response into their work, training usually focuses on mechanisms for folding the new responses in with the existing approach, and practical strategies for undertaking any new tasks.

Step 4: Monitoring, feedback and regulation

This is the section that makes the chronological element of this work explicit. Where good operating frameworks have been established, energy may be best spent ensuring there is consistency between the goals and the implementation at different levels, and that appropriate and functional linkages have been made with other sectors. This will require monitoring and feedback loops.

Where responses are newly developed, monitoring and feedback are also key, in order to check that the responses are working as intended and are producing the desired results. This is because sometimes, with the best intentions in the world, we get it wrong, and while getting it wrong doesn’t reflect well on the agency, it can have even worse implications for individuals. For example, a health care agency may have an appropriately developed policy of routine screening for the identification of intimate partner violence. A well-trained staff member may conduct the screening, and note presence of violence by a current partner in the notes. The notes may be given to the client, or be accessible to other family members. The current violent partner may read

the notes, and retaliate against the client for disclosing. So, subtleties of implementation can be very important.

The experience of monitoring responses in the justice sector suggests that monitoring needs to be carried out by external advocates, not by those within the system. This offers the potential to minimise the gap between victims' realities and the way the system responds. If our intervention goal is to improve victim safety, we will only make progress if our responses are squarely based on victims' realities.

Regulations and sanctions are other ways of reinforcing the activity of different sectors, and the impact of changes both internally and externally. Rigorously enforced sanctions can be key to actually changing public behaviour. For example, rigorous enforcement of protection orders can send a strong signal that breaches of these orders will not be tolerated, and may lessen the likelihood of repeated offences. Without both the threat and actuality of sanctions, those who are not convinced of the 'rightness' of non-violence will not change their behaviour. Sanctions can also be administered by other cultural institutions, such as national sporting bodies or religious organisations.

Step 5: Revise and refresh

Information obtained as part of the monitoring and feedback process may prompt significant revision of a sector's response. The revision may be radical, challenging the basic assumptions that the response was built on. An example is the fairly radical changes that have taken place in the justice system, based on the information that the 'old' responses weren't contributing to safety for victims, or accountability of perpetrators. Alternatively, the revision may reflect a change in emphasis based on new information, such as the transition in programmes for perpetrators from 'anger management' to 'non-violence'. Major changes in the underlying assumptions on which actions are based will, of course, require substantial revision of the programmes or initiatives.

In other cases, the revision required may be more moderate, in some cases just a reminder of an already developed response, such as the police arrest policy, first issued in 1987 and re-issued in 1992, each time accompanied by some renewed training and other organisational support. It may be a refinement of something that is mainly working well.

New and existing responses will need to be reviewed in light of ongoing information, on a regular basis. This step is important not only for making sure that the goals continue to be achieved, but to revisit how this sector/level response is working with the rest of the system. There may be implications here if there is change in other components of the overall system (responses from other sectors at different ecological levels).

7.2.1 Working across sectors: collaboration and co-ordination

Collaboration and co-ordination are words frequently used in the context of family violence intervention work. Sometimes the co-ordination referred to can be conceptualised as 'within sector' work, such as the efforts made by the justice sector to get all of their systems operating in concert, from the initial police response through to appropriate court processes, sentencing and/or referral to programmes, and appropriate responses in case of breaches of protection orders. In other cases, the collaboration referred to is across sector boundaries, often involving joint work between victim and children's advocates, police, criminal justice staff such as probation officers and staff from men's programmes. Fewer examples exist that involve representation from other sectors such as health, education or faith communities.

The boundaries between sectors may be almost as important as the sectors themselves. The boundaries represent the opportunity to pass individuals from one helping system to another. While they are represented as black or dotted lines on the diagram, what they represent in the real world is the degree of co-ordination that exists (or fails to exist). If a handover is fumbled, or if the receiving agency doesn't have the resources to follow up appropriately, then there is opportunity for people to slip through the gaps (Busch et al 1992). Sadly, this can be the time when we face episodes that become national tragedies, and which can devastate individuals, families and communities. If we are serious about prevention, our challenge is to make sure that individuals:

- a. have a clear understanding of their role in preventing and responding to violence
- b. have a clear understanding of what actions they need to take
- c. have the resources to follow through.

Another key factor is the 'co-ordinating agency', a group of people or agency with the mandate to co-ordinate across sectoral boundaries. There is a need to ensure that co-ordination and collaboration exist at all ecological levels with communication between them. If managed effectively, co-ordinating agencies should ensure that duplication of effort is reduced, that lessons learned from previous implementation of programmes is not lost, and that knowledge is shared across sectors. Given that there is much work to be done, and each sector holds a unique piece of the puzzle, effective collaboration and co-ordination should also work to discourage 'turf wars' and 'patch protection'. These can be an extensive energy drain and prohibit activity that moves us toward our goals. The recent establishment of the Taskforce for Action on Violence within Families and Ministerial Team holds the promise of being able to achieve more co-ordinated action.

7.2.2 Prioritising and resourcing responses

The conceptual framework outlined above presents steps for working through each sector across all ecological levels, building in mechanisms for monitoring and ongoing improvements in response and ensuring that collaboration and co-operation operate at all levels. While conceptually simple, the framework and suggested steps for putting the framework into action represent an enormous amount of work that needs to be done – and there are not unlimited pots of money or people resources to do the work. This means we need to be strategic in the decisions we make about what to do next, look for successful models to build on and develop strategic partnerships wherever possible.

Strategic decisions might be made on a range of different criteria, such as a desire to fill a significant gap in the overall framework. These could include decisions to seek to engage a sector where there has been little activity around the prevention of family violence (eg the faith community), or decisions to seek to extend activity within a sector to different ecological levels (eg extend model programmes on employer responses to intimate partner violence to other ecological levels, such as the institutional level).

Wise allocation of resources will be dependent on a clear assessment of what is going on at present, and developing responses that are appropriate to the scale that each sector is ready for. For example, it is clear that, at present, the media and the faith communities do not have well-developed conceptions of how they might work to address family violence. As a consequence, any suggestion that an extensive programme of work be rolled out within these sectors would be clearly ludicrous. But, as there is a need to engage these sectors, good arguments could be made for commissioning and carrying out smaller-scale projects that could, for example, help to articulate the role of these sectors in responding to family violence or promoting healthy relationships and provide examples of how these goals could be put into practice. For other sectors, where

responses are already more well developed (eg justice, health), strategically directed effort might suggest concentrating more on the implementation and monitoring of programmes, and/or the development of new activities to fill identified gaps.

Strategic work also means seeking to avoid duplication of effort, and working to identified strengths. In this context, two ways forward are the identification of key partners, and piggybacking on, or adapting, strategies used successfully. In the family violence prevention field, education is a key sector that has not yet come strongly to the table. Yet education and its partners already have a number of programmes that are (potentially) available universally (eg Keeping Ourselves Safe, Kia Kaha, Cool Schools) or to high-risk children (eg TRAVELLERS). These could be used as a platform for building programmes that address other aspects of non-violence and healthy relationships.

There are also other partners who are natural allies to the family violence community, and whose work could be mutually reinforcing. Examples include Rape Crisis Auckland, which already runs programmes for the prevention of sexual assault in some high schools, or ALAC, which is currently running a media-based programme to change attitudes and ultimately behaviours related to binge drinking. There may also be successful initiatives from other interest groups that we can learn from, such as the consumer and research-led media initiative to change attitudes to mental illness (the Like Minds, Like Mine campaign).

Insights and methods from other disciplines (eg sociology, anthropology) may help to inform us of mechanisms that may influence other ecological levels. These may include social networking at the family/relationship level (Myers, McGrady, Marrow and Mueller 1997), or the community readiness model at the community level set out in Box 7.2. This model may help us tailor our interventions to communities, and track incremental changes over time.

BOX 7.2: COMMUNITY READINESS MODEL

The Community Readiness Model was developed following the recognition that communities exhibit substantial variation in their interest and willingness to try new prevention strategies. For example, some communities may not publicly recognise the existence of a problem in their local community, while other communities may express considerable interest in an identified problem, yet have little knowledge about what to do about it, and still other communities may have highly developed responses to the same problem. Without understanding this variation, many supposedly 'effective' programmes might be doomed to failure, or waste considerable resources trying to instigate programmes that are beyond the community's ability to support.

The Community Readiness Model establishes a mechanism for systematically assessing a community's readiness to initiate or maintain prevention programmes around a specific issue. Utilising semi-structured interviews with key informants in each community, the model can be used to map a community according to a nine-stage model of community readiness. The stages are:

Community tolerance which suggests that the behaviour is accepted and considered normative.

Denial involves the belief that the problem does not exist or that change is impossible.

Vague awareness involves recognition, but no motivation for action.

BOX 7.2: COMMUNITY READINESS MODEL (continued)

Preparation involves active planning.

Initiation involves implementation of a programme.

Institutionalisation indicates that one or two programmes are operating and are stable.

Confirmation/expansion involves recognition of limitations and attempts to improve existing programmes.

Professionalisation is marked by sophistication, training and effective evaluation.

Each of these stages is linked with specific, action-oriented strategies designed to assist communities to move to the next stage. The model thus has utility as a planning tool for deciding what might be the optimal targeting of resources or programmatic activity within a community. Further, if community readiness assessment is undertaken again at a later interval, it can be used to track community progression through the stages of response, which may provide us with measures of intermediate outcomes toward our goals.

Source: Edwards, Jumper-Thurman, Plested, Oetting and Swanson 2000.

Ultimately, decisions as to which sectors to engage next are likely to be influenced by a combination of strategy and pragmatism, giving consideration to which sectors we need to involve because of the unique role they fill in our society, where we can make strategic links, and finding champions within the field who are willing to extend their range of practice.

Finally, there must be recognition that resourcing needs to be appropriate to the scale of the task that is being set. Small projects may only need small budgets, but big ones will need bigger budgets. While there are always extreme challenges in wresting money out of already committed budgets, it must be recognised that family violence is already extremely costly to the country. Adequate money spent on prevention has the potential to cost us less than picking up the pieces.

7.2.3 Who can do the work?

The fields of policy, practice, advocacy and research need to work together if advances in preventing family violence are to be made. Policy-makers have the ability to keep the elimination of family violence on the public agenda, as well as leveraging resources to make the work happen. Skilled practitioners understand the dynamics and structures of their fields, and can design workable responses that complement the existing scope of their work. Advocates have a vital role because they hear the stories of many victims and, as a consequence, have access to information about how violence impacts on major areas of victims' lives. This can lead to identification of holes in the system, and keep up the pressure for ongoing improvement until we get it right. Researchers, if they do their job well, have the ability to: document the extent of the problems; set up surveillance systems that will help us track the scale of the problem (see Box 7.3); unpack core beliefs that can underpin violent behaviour; help to work through conceptual issues; and help to track change and identify areas that need improvement. We will need everybody at the table.

BOX 7.3: MEASURING CHANGES OVER TIME: PUBLIC HEALTH SURVEILLANCE

Public health surveillance is a term used to describe the systematic collection and reporting of information (usually incidence and prevalence) over time.

Traditionally, surveillance involves systematic, ongoing collection, analysis and interpretation of data already available from sources such as mortality and inpatient hospitalisations, or other service-based statistics. These data are typically collected for other agency-related purposes, but can later be extracted and used for surveillance purposes. In addition to allowing examination of trends over time, these data are typically inexpensive to collect. However, information collected for general purposes may be of limited value in tracking family violence, as the relationship of the perpetrator to the victim is often not recorded. Information from service agencies may also be limited, because of bounds of confidentiality.

International standards and suggested minimum data elements have been developed for public health surveillance of intimate partner violence (Saltzman et al 1999) and sexual violence (Basile and Saltzman 2002). Koziol-McLain and colleagues (2002) reviewed possible indicators collected by the Ministry of Health, Ministry of Justice, Department of Courts, Department of Corrections, Police, ACC, CYF, the National Collective of Independent Women's Refuge Inc. and Age Concern New Zealand Inc.

Surveys, on the other hand, involve systematic data collection from a representative sample of the population of interest for analysis and interpretation. Survey data are collected directly from individuals affected by the condition under surveillance. Surveys allow flexibility in the types of questions that can be asked and the level of detail of information that can be collected, since they do not rely upon information already existing in official agency records. Unlike traditional surveillance, surveys offer the opportunity to gather information from those who have experienced violence and from similar individuals who have not for purposes of comparison. However, they are sometimes more expensive than record reviews.

New Zealand is fortunate in having data on the extent of intimate partner violence from a variety of local and national surveys. With the exception of the NZNSVC, however, these do not provide information on an ongoing basis that would allow monitoring of trends over time. One option for obtaining some of these data on an ongoing basis might be to 'piggy-back' modules for assessing incidence and prevalence of violence onto other routine surveys (eg health surveys, reproductive health surveys). Some international modules have been developed such as the Behavioral Risk Factor Survey (BRFS)¹⁰ in the USA. There have, however, been no population-based surveys of child abuse or elder abuse, though some population-based data are available on child abuse through large cohort studies.

¹⁰ www.wonder.cdc.gov/wonder/sci_data/surveys/brfs/brfs.asp

8. CONCLUSION

The first sections of this paper outline some of what is known about the scope and consequences of family violence, as well as some of what is known about interventions. Beginning in Section 7, a conceptual model is outlined in order to provide a framework for clarifying what has been done, and areas that may require further engagement and development if we are to develop a culture that not only does not tolerate violence, but that actively fosters healthy relationships.

New Zealand is, perhaps, one of the countries in the world that is best positioned to achieve this goal. While we have disturbingly high rates of violence, and problems in areas such as the growing gap between rich and poor that are likely to compound the issue, we also have a sound legislative base, a health system that is starting to take the problem seriously, a strong NGO voice and more government will to act on the problem than has been seen in years. By international standards, we have a small well-resourced population, with high levels of education, and are not crippled by war or internal conflict.

Developing a culture of non-violence will require both patience and impatience. Change takes time. We can be disheartened by this reality, or we can recognise the realistic timeframes involved in shifting large interconnected systems, plan and implement sustained investment and seek to measure incremental changes along the way. Recognising that it will take time to implement change and produce rigorous research should not be an excuse for inaction. Family violence is affecting many New Zealanders now, and promising programmes and efforts at prevention and intervention need to be supported.

The NZPPD closed their report with a quote from the Roper Report, written in 1987:

The public through the submissions made to this Committee, has expressed its concern at the increase in violence and has called on it to find solutions. It is not unfair to say that the public now has the community it deserves. For the last two or three decades permissiveness has gone unchecked; domestic violence is rampant; the 'macho' image has been encouraged by advertising for commercial interests to the detriment of women; aggressive behaviour and violence in 'sport' has become accepted; pornography has become accepted as the norm, as has violence in the visual media; racism has increased; economic inequality with its attendant stresses and frustrations has increased; illiteracy and lack of parenting skills are common and awareness of spiritual values is sadly lacking... No one can afford to be complacent about the problem. Violence occurs by acts of commission and omission and we are all responsible.

Today, many people are saying that this is not how they want New Zealand to be. So maybe now is the time to start the dialogue about the type of society we do want, and how we are going to get there. If we approach this task in a conscious, comprehensive and sustained way, rather than letting it occur by default, we may be able to get to the place and time where healthy, well-functioning relationships are the norm, and are recognised to be of value not only to individuals and their families, but to society as a whole.

9. RECOMMENDATIONS

This author endorses the recommendations of the NZPPD (2005). In addition, the following recommendations are offered for the policy, research and practice communities.

9.1 JOINT RECOMMENDATIONS FOR POLICY, RESEARCH AND PRACTICE

- > Clarify what we are trying to achieve:
 - minimum standards: victim safety and offender accountability, violence not tolerated
 - ideal goal: develop better public understanding of healthy relationships and equip individuals, families and communities with the component skills and structural supports to sustain these.
- > Adopt an overall framework for understanding and responding to family violence that recognises the importance of sustained response in multiple sectors across multiple ecological levels, and that will guide future action and can be monitored, researched and improved.
- > Support further investment and activity in primary prevention, particularly at the institutional, community and societal levels.
- > Develop and use clearer language including more consistent definitions, and better language describing the unit that we are seeking to change, for example:
 - universal interventions: approaches aimed at groups or the general population without regard to individual risk
 - selected interventions: approaches aimed at those considered at heightened risk for violence (eg having one or more risk factors)
 - indicated interventions: approaches aimed at those who have already demonstrated violent behaviour.
- > Recognise linkages between types of family violence.
- > Consider gender and cultural issues in developing responses.
- > Work collaboratively to establish priorities for response. Key sectors requiring more developed responses include education, media and faith communities.

9.2 POLICY-MAKERS

- > Consider ways to influence the legislative, policy and institutional framework that will support non-violence.
- > Balance the need to provide services with the need to invest in prevention.
- > Recognise and support the need for more specialised programmes for identified victims and perpetrators.
- > Invest more in the research infrastructure, and consider ways in which to foster collaboration rather than competition. New Zealand research expertise in this field is very limited.

Note: Development of further strategies for responding to family violence is not required (NZPPD 2005). Commissioning of further research reviews is also contraindicated at this time, as a number of excellent local and international resources are available on this topic. Policy-makers wishing to broaden their understanding of this topic are referred to the following resources (Chalk and King 1998; Davies et al 2002; Krug et al 2002; Davies et al 2003).

9.3 PRACTICE

- > NGOs have a unique role in ensuring that the goals of activity in this area remain true to the needs of those who are victimised, and to the larger goal of elimination of family violence.
- > Service providers should work to ensure that their administrative and practical links with other agencies are strong and well co-ordinated, to minimise the possibility of 'gaps' in response.
- > Service providers in key sectors (eg education, health, etc) should be supported and enabled to gain further understanding of the scope, consequences and dynamics of family violence, and to develop links with specialist family violence referral services. Institutional support should be provided for these efforts.
- > Specialist family violence practitioners should work to develop more refined and specific programmes for victims and perpetrators. Specialised programmes are likely to be needed for victims of family violence with mental health issues; perpetrators with substance abuse problems.

9.4 RESEARCH

- > Develop public health surveillance tools for measuring changes in the incidence and prevalence of family violence over time.
- > Work to further identify information on risk and protective factors, particularly at the community and societal levels.
- > Work with practitioners and policy-makers to develop, implement and evaluate primary, secondary and tertiary prevention programmes.
- > Identify and/or develop new mechanisms for tracking change at the family/relationship, institutional, community and societal ecological levels.
- > Identify and/or develop evaluation techniques that will help inform the implementation of programmes.

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11. TIMELINE OF FAMILY VIOLENCE PREVENTION INITIATIVES IN NEW ZEALAND

1968	Guardianship Act 1968 passed
1970	<i>Child Rearing Practices in New Zealand</i> published – results of a study conducted in the early 1960s (Ritchie and Ritchie 1970)
1972	Department of Social Welfare (DSW) formed
1973	First women's refuge opened in Christchurch
1974	First rape crisis group established in Auckland Children and Young Persons Act 1974 passed (repealed 1989)
1975	Establishment of halfway house refuge in Auckland and Wellington Rape Crisis
1976	Dunedin women's refuge opened Inter-departmental committee on child abuse (Departments of Health, Social Welfare, Education)
1977	11 new women's refuges established First Parentline groups established in Auckland and Hamilton
1979	First national gathering of women's refuges International Year of the Child New Zealand Committee for Children established (Department of Social Welfare 1984) National Advisory Committee on the Prevention of Child Abuse established First national gathering on child abuse held in Dunedin International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted by UN General Assembly
1980	Refuges begin process of forming a national collective Family Court Act 1980 Family Proceedings Act 1980 Pilot projects to trial child protection teams in Dunedin and Hamilton
1981	National Collective of Independent Women's Refuges established National Advisory Committee on the Prevention of Child Abuse established by the Minister of Social Welfare
1982	Domestic Protection Act For Men Support begins in West Auckland – first group working with male abusers First national symposium on child abuse prevention, held in Palmerston North
1983	Publication of <i>A Socio-economic Assessment of Women's Refuges</i> DSW establishes women's refuge funding programme NZ Child Abuse Prevention Service established – association of local Parent Line/Parent Help groups
1984	First national gathering of men's anger management groups DSW establishes funding for rape and sexual abuse services Rape Crisis groups move to form a national collective Pacific Island Women's Project established, focusing on rape and sexual abuse of Pacific Island women Whakamaru Tinana formed – Māori women's self-defence groups NZ Government ratifies UN Convention on the Elimination of Discrimination Against Women

1985	<p>National conference on family violence held at the Police College, Porirua</p> <p>Te Kākano o Te Whānau groups established, offering sexual abuse counselling services to Māori</p> <p>Review of Refuge instituted by the Minister of Social Welfare</p> <p>(i) National Collective of Independent Women's Refuges first publishes <i>Fresh Start: A Self Help Book for New Zealand Women in Abusive Relationships</i> (NCIWR 1985)</p> <p>(ii) CEDAW ratified</p>
1986	<p>Refuge responds to need for culturally appropriate services with establishment of Māori women's refuges, and implements a bicultural organisational model</p> <p>National Collective of Rape Crisis and Related Groups of Aotearoa formed</p> <p>Te Kākano o Te Whānau national organisation established</p> <p>Police research into domestic violence undertaken</p> <p>Family Violence Prevention Coordinating Committee (FVPCC) formed</p> <p><i>Puao-Te-Ata-Tu</i> published (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare 1986)</p>
1987	<p>Mental Health Foundation conference on family violence</p> <p>Victims of Offences Act passed</p> <p>Victims Task Force set up for five-year period</p> <p>Police Family Violence Policy adopted</p> <p><i>Review of the Children and Young Persons Bill</i> (Department of Social Welfare 1987)</p> <p>Report of the Ministerial Committee of Inquiry into Violence (Roper Report)</p> <p>Launch of Keeping Ourselves Safe Programme for primary schools (developed by the Police's Law-Related Education Programme)</p> <p>FVPCC Statement on Family Violence issued; Tūkinō Tangata (Māori caucus) established</p> <p>Hutt Family Violence Network established – first community-based inter-agency co-ordinating body</p>
1988	<p>Men of Aotearoa formed – a national grouping of men's groups working in the family violence area</p> <p>Telethon on violence prevention held, managed by the Home & Neighbourhood Trust</p> <p><i>Attitudes to Family Violence: A Study Across Cultures</i> published (Synergy Applied Research & FVPCC 1988)</p> <p>Reach Out public education campaign launched, co-ordinated by FVPCC</p>
1989	<p>Children, Young Persons and Their Families Act 1989</p> <p>Office of the Commissioner for Children established</p> <p>Convention on the Rights of the Child adopted by the UN General Assembly</p>
1991	<p>Men for Non Violence Network established (based on Men of Aotearoa)</p> <p>Te Rūnanga Tāne established (Māori men's network)</p> <p>FVPCC conference, Family Violence: Prevention in the 1990s, held in Christchurch</p> <p>Hamilton Abuse Intervention Pilot Project launched</p> <p>UN adopts Principles for Older Persons</p>
1992	<p>NCIWR study of children in Refuge, <i>Treasure the Child</i>, published</p> <p>Crime Prevention Action Group established by government to develop a national strategy for crime prevention</p> <p>Victims Task Force published an abridged version of a report on protection orders, <i>Protection from Family Violence</i></p> <p>Child abuse guidelines for health services published by the Department of Health</p> <p>Waitakere Anti Violence Essential Services (WAVES) formed – co-ordination of local response to family violence in West Auckland</p> <p>Domestic Violence Education Intervention Project (DOVE) opened in Hawke's Bay, based on HAIPP model</p>
1993	<p>Police Family Violence Policy re-emphasised in Police Strategic Plan. Guidelines reissued</p> <p>Crime Prevention Unit established in the Prime Minister's Department</p> <p>UN Convention on the Rights of the Child ratified</p> <p>UN Declaration on the Elimination of Violence Against Women adopted; welcomed by NZ Government</p> <p><i>The Measurement of Family Violence: A Critical Review of the Literature</i> (Lapsley, Social Policy Agency 1993)</p>

1994	<p><i>New Zealand Economic Cost of Family Violence</i> published (Snively 1994)</p> <p>NZ Crime Prevention Strategy launched</p> <p>Family Violence Advisory Committee established by Minister of Social Welfare</p> <p>Report of inquiry into Family Court proceedings involving Christine Madeline Bristol and Alan Robert Bristol (Davison, Department of Justice 1994)</p>
1995	<p>Domestic Violence Act 1995 passed</p> <p>Guardianship Amendment Act 1995 introduced a presumption that violent parents should not have unsupervised access to their children</p> <p>Beijing Platform for Action</p> <p>Men for Non-Violence changes to Te Kupenga Whakaoti Mahi Patunga/National Network of Stopping Violence Services, becomes a co-gendered and bicultural organisation and commits to a focus on women's and children's safety</p>
1996	<p><i>New Zealand Government Statement of Policy on Family Violence</i> released (Department of Prime Minister and Cabinet 1996)</p> <p><i>Good Practice Guidelines for Coordination of Family Violence Services</i> published (Department of Social Welfare, Family Violence Unit 1996)</p> <p><i>The Economic Cost of NCIWR Refuge Services</i> published (Snively 1996)</p> <p><i>Hitting Home</i> survey published (Leibrich, Paulin and Ransom 1995)</p> <p>Crime Prevention Package (Budget 1996)</p> <p>Ministry of Health Guidelines for the Development of Practice Protocols</p> <p>MSP: Family Violence Unit, established</p> <p><i>Breaking the Cycle: Interagency Protocols for Child Abuse Management</i> published (CYPS 1996)</p>
1997	<p><i>1996 Women's Safety Survey</i> published (Morris 1997)</p> <p>First national survey of crime victims published (Young, Morris, Cameron and Haslett 1997)</p> <p>DSW led Strengthening Families strategy approved by Cabinet</p> <p><i>Māori Family Violence in Aotearoa</i> published (Balzer, Haimona, Henare and Matchitt 1997)</p> <p>NZ Police, National Collective of Independent Women's Refuges and CYPFA meet to develop interagency response to family violence and joint training initiative</p> <p>Ministry of Justice Responses to Crime strategy agreed by Cabinet</p>
1998	<p><i>An Agenda for Family Violence Research</i> (Department of Social Welfare, Family Violence Unit 1998)</p> <p><i>Family Violence: Guidelines for Health Sector Providers to Develop Practice Protocols</i> published (Ministry of Health 1998)</p> <p>Shakti Asian Women's Support Group establish the first ever refuge/safehouse for Asian/ethnic women in NZ</p> <p><i>First Responses to Crime: Annual Review 1998</i> report published (Ministry of Justice 1998)</p>
1999	<p><i>Protecting Women and Children: An Interagency Response to Family Violence</i> training kit jointly developed by NZ Police, National Collective of Independent Women's Refuges and CYPFA. Joint-agency training of Police, social workers and community advocates is undertaken around the country</p> <p>Māori Provider Development Fund established, administered by Te Puni Kōkiri</p> <p>Te Puni Kōkiri to develop <i>Family Violence Strategic Agenda for Iwi/Māori</i>.</p> <p>Family Violence Focus Group co-convened by the Ministry of Social Policy and Crime Prevention Unit, comprising representatives from both government and non-government sectors. The focus group worked on developing a strategic plan for family violence</p> <p>Children and Family Violence: Effective Interventions Now conference</p> <p><i>Second Responses to Crime: Annual Review 1999</i> published (Ministry of Justice 1999)</p> <p>Family Violence Unit disbanded</p>

2000	<p>James Whakaruru investigation report published (Office of the Commissioner for Children 2000)</p> <p><i>Improving Outcomes for Women and Children Using Refuge Services</i> (National Collective of Independent Women's Refuges 2000)</p> <p><i>Domestic Violence Act Process Evaluation</i> (Barwick, Gray and Macky, Ministry of Justice 2000)</p> <p><i>Family Violence: The Health Care Response; Bibliography</i> published (Elvidge 2000)</p> <p><i>New Zealand Health Strategy</i> launched (Ministry of Health 2000)</p> <p><i>If I really loved him enough, he would be okay: Women's accounts of male partner violence</i> (Towns and Adams 2000)</p>
2001	<p><i>Review of Family Violence Prevention in New Zealand: Plan of Action</i> released (Maharey 2001)</p> <p><i>Family Violence Strategic Agenda for Māori</i> report published (Te Puni Kōkiri 2001)</p> <p>Child Abuse Prevention Service NZ establishes a national office in Wellington</p>
2002	<p><i>Free from abuse</i> published (Hand et al 2002)</p> <p><i>Family Violence Intervention Guidelines</i> published (Fanslow 2002)</p> <p><i>Te Rito: New Zealand Family Violence Prevention Strategy</i> released (Ministry of Social Development 2002)</p> <p>Te Rito Advisory Group established involving government and non-government agencies in overseeing the 18 Areas of Action for preventing family violence in Aotearoa New Zealand</p> <p>Victim's Rights Act 2002</p> <p>WHO publishes <i>World Report on Violence and Health</i> (WHO 2002)</p> <p>WHO Global Campaign for Violence Prevention launched</p> <p><i>Whānau Violence: A Māori Conceptual Framework</i> report published (Kruger 2002)</p> <p>Rape Crisis national office in Wellington is closed down</p>
2003	<p><i>Care and Protection Blueprint</i> published (Ministry of Social Development 2003)</p> <p>Aplin investigation report published (Office of the Commissioner for Children 2003)</p> <p>Second Shakti Safehouse/refuge opened</p> <p>Children's Commissioner Act 2003 passed</p> <p>Families Commission Act 2003 passed</p> <p>Work and Income New Zealand Family Violence Intervention Programme piloted</p> <p>Women's Refuge website launched www.womensrefuge.org.nz</p> <p><i>Silencing Talk of Men's Violence Towards Women</i> (Towns, Adams and Gavey 2003)</p>
2004	<p><i>Transforming Whānau Violence</i> published (Kruger 2004)</p> <p>Families Commission established 1 July 2004</p> <p>Families and Community Services, MSD established to co-ordinate and implement Work and Income Family Violence Intervention Programme</p> <p><i>The Implementation of the Domestic Violence Act 1995</i> report released by the National Collective of Independent Women's Refuges</p>
2005	<p>New Zealand Family Violence Clearinghouse established, www.nzfvc.org.nz</p> <p>Open Hearing, NZ Parliamentarians Population Development</p> <p>31 March: Ministry of Social Development workshop on family violence</p> <p>Ministerial Group</p> <p>Opportunities for All New Zealanders identifies family violence as area for priority action by the Government over the next 3-5 years</p> <p><i>Domestic Violence and Harassment Legal Education Kit</i> published (Legal Services Agency 2005)</p>

Note: Activities before 1993 identified by the Family Violence Unit, Ministry of Social Policy.

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<http://familyservices.govt.nz>

Families Commission
www.nzfamilies.org.nz

Family Violence Intervention Programme
www.familyservices.govt.nz/documents/about-us/info-sheet-8.pdf

New Zealand Family Violence Clearinghouse
www.nzfv.org.nz

Shakti Women's Centre
www.shakti.org.nz/pages/women/foundations.htm

WHO Global Campaign for Violence Prevention
www.who.int/violence_injury_prevention/violence/global_campaign/en/

APPENDIX A

ABOUT THE AUTHOR

Dr Janet Fanslow is a Senior Research Fellow with Social and Community Health at the School of Population Health. She has been engaged in violence prevention research since 1989, and has worked on descriptive epidemiological studies of violence, the development and evaluation of programmes to promote appropriate health care response to victims, national and regional consultation process to identify priorities for research, activities related to the standardisation of definitions and measurement of partner abuse, and comparative studies of batterer intervention programmes. She is co-author of the book *Intentional Injury in New Zealand*.

She worked with the Family and Intimate Violence Prevention Team of the US Centers for Disease Control and Prevention from 1997 to 1998, as part of an HRC post-doctoral fellowship.

Since returning to New Zealand, she has carried out a national stocktake on programmes for the prevention of violence against children, and developed model protocols for health care providers' response to victims of child abuse, partner abuse and elder abuse as part of the Ministry of Health's Family Violence Implementation project. She is co-author of the document *Evaluation of Te Rito: Ideas to Get Started*, prepared for the Ministry of Social Development by the Auckland University of Technology.

Her current project is an Health Research Council-funded population-based study of violence against women. This project is part of a World Health Organization multi-country study, with a cross-section of almost 3,000 New Zealand women. It seeks to identify the prevalence of intimate partner violence, document its health consequences, identify risk and protective factors, and identify strategies and services used by victims of IPV.

She served as an Expert Advisor for the Ministry of Health's toolkit on the prevention of interpersonal violence, on the Advisory Group for the Ministry of Health Family Violence Prevention Project, and is currently a member of the Stakeholder Reference Group for the NZ Injury Prevention Strategy.

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