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Kaitohutohu Mātanga Pūtaiao Matua ki te Pirimia
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Every 4 minutes: A discussion paper on preventing family violence in New Zealand

Date: 6 Nov 2018

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Foreword

This is the first major report to be released from my Office since I took over in July. It provides some continuity from Sir Peter Gluckman's tenure, in that it is the third in a series exploring factors that have led Aotearoa, New Zealand to have a high incarceration rate. Like the first two, the primary author is the Chief Science Advisor to the Justice Sector, Dr Ian Lambie. You can read about Ian's background and the lens he brings to his work, below.

The previous two reports are available on our website. *Using evidence to build a better justice system: The challenge of rising prison costs* argued that the evidence pointed to a need for radical change of the way we view and manage the justice system, towards a restorative approach. *It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand* highlighted the systemic failure to consider and act on the evidence synthesised in previous reports to reduce youth offending. This third report is arguably the most contentious and delves into the role of family violence as a precursor to offending and as a community – not an individual – problem.

As with all scientific endeavours, Ian has examined the evidence through particular lenses, as a trauma-informed psychologist in the child, youth and justice sectors, and others will have different interpretations. The report is not intended to present a definitive opinion, but rather to start conversations and encourage more discussion in the public arena. We hope that it will stimulate more research from different groups with different perspectives and world views, especially from Māori and Pasifica researchers. As Ian asks us to consider, how do we stop getting in the way of Māori and Pasifica flourishing, and reverse the trauma of colonisation and disadvantage? New data will raise more questions, and suggest new answers. Different researchers and different communities will interpret the data in different ways. But all will agree that as a country we need to improve – a call-out for family violence every 4 minutes in Aotearoa, New Zealand is a shocking statistic through any lens and Ian's report brings this into sharp focus.

The report is endorsed by my Office on behalf of the Forum of Chief Science Advisors.

Professor Juliet Gerrard FRSNZ

Juliet Gerrard

Dr Ian Lambie is Chief Science Advisor to the Justice Sector (Ministry of Justice, Department of Corrections and Police) and Associate Professor in Clinical Psychology at the University of Auckland, where he teaches clinical, forensic, child and adolescent psychology. His specialist clinical and research interests are in child and adolescent mental health, childhood trauma and youth justice, building on more than 30 years' experience working with children and adolescents with severe conduct problems and trauma, and their families, carers and service-providers. "I hope that this report will be discussed in high-school classrooms, business boardrooms, sports clubs, churches, shearing sheds, at smoko time on building sites, on the marae, and in the chambers of Parliament. If we want real change, then that is what is needed – everyone knowing about and beginning to think about what we can do, collectively, to end family violence."

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Preamble

1. This is a discussion paper on what New Zealand can do to prevent family violence. It takes the position that family violence is a solvable problem. Family violence can be seen as largely a "symptom" of underlying social and psychological issues, that are indeed multiple and complex, but are associated with many of the drivers of other social concerns. In the end, there is a lot to be gained for New Zealand by the unleashing of the social and economic wellbeing of children, families, communities, businesses, and services that would follow the reduction or elimination of emotional, physical, sexual, and psychological violence that tangle and restrain our homes and our relationships.

2. Agencies use the "every 4 minutes" idea to try to get at the scale of the big trouble that happens behind closed doors in all suburbs, that affects the childhoods of many of us, and that impacts on adult relationships, family relationships, and thus the next generation. It is a cycle that can be stopped.

3. "Every 4 minutes" sounds ridiculous. There are not police cars tearing by, hauling angry, violent bashers out of family homes every 4 minutes. But that is part of the problem. Our stereotypes of how family violence and child maltreatment occur – and to whom – persist, with a sense that it is something that doesn't happen to "us" and "not in our street".

4. The number is derived from the 158,921 care and protection notifications, including police family-violence call-outs, that Oranga Tamariki Ministry for Children received in 2016/17, relating to almost 60,000 children. There are 525,600 minutes per year; hence, one notification every 4.42 minutes. Of course, not all of those reach the "threshold" for court cases and bureaucratic involvement, but they hint at what is so hard to measure. And those children and families live in our neighbourhoods and communities, go to our schools, support our sports teams, shop in our supermarkets—and some end up in our criminal-justice system.

5. As discussed in the previous two reports on the criminal-justice system, most offenders have, themselves, been targets of violence; this precedes and continues into their criminal-justice careers. It is important that we understand this as a society at all levels. For example, 80% of child and young offenders that come to the attention of the state have experienced family violence; most (87%) young offenders aged 14 to 16 years old in 2016/17 had had prior reports of care-and-protection concerns made to Oranga Tamariki; 75% of women in prison have reported sexual and family violence; and a history of sexual abuse is the strongest predictor of reoffending by young females at 12-months follow-up. These trajectories can be changed. How can we do that in New Zealand?

6. Systems that support more collaboration across services is vital. There is a case example of a child who, by age 7 years, had already had 26 family-violence episodes reported, 32 A&E visits (for respiratory illness, but often with a comment that the caregiver seemed "stressed") leading to a DHB "child protection" alert with services offered, Oranga Tamariki involvement, an NGO referral; assessment after assessment and bits of intervention, often ending in "did not attend" or "mother was hard to engage" and a closed file. It is enormously frustrating for those in the field not to have the resources to join the dots for her and her child, the abusive father, and the other children and family members affected. What would it take for that to happen?

7. This is a discussion paper using findings from current research to prompt informed reflection on preventing violence in New Zealand and to encourage us all to take some responsibility for beginning to repair the damage and distress that family violence does to the society to which we all belong. If we want real change, then that is what is needed – everyone knowing about and beginning to think about what we can do collectively about family violence. It is a report based on "Western" science that nevertheless accords with what the real experts know (that is, those who have experienced violence, and those working in the field) – that this can and must be stopped.

Executive summary

Whatever form it takes, family violence is a fundamental violation of human rights and is unacceptable in any form, in any community and in any culture. It is everyone's responsibility to reject and prevent violence.[1]

1. This series of reports relates to the criminal-justice system. Talking about the cumulative effects of family violence and child maltreatment, and the wellbeing of babies, seems a long way from arguments about the prison muster, but that is where the evidence says we must begin.

2. **Family violence** includes child maltreatment (physical abuse, sexual abuse, emotional abuse or neglect), intimate-partner violence (physical, sexual or emotional violence from a partner or ex-partner) and intrafamilial violence (between siblings, adult children to parents and other violence between relatives). It used to be called "domestic violence".

3. **Exposure to family violence has substantial impact.** The nervous and emotional systems, the immune system and metabolic systems of young children are affected by the stress of family violence, impacting on lifelong physical and mental wellbeing. Managing feelings (especially aggression), information-processing, reading social cues, and problem-solving skills can all be hampered by the extremely high levels of stress that children experience. Increased child anxiety and trauma symptoms are common.

4. **Parenting is affected by family violence,** thwarting parents' ability to nurture their children in the way they desire. **Intergenerational transmission of violence, neglect, and maltreatment** is far too common but not inevitable. If both partners have been abused in childhood, and witnessed violence between their own parents, the odds that their adult relationships will be violent are increased, because that is what they have had modelled to them. Violence is "normal".

5. **Intimate-partner violence is the leading cause of female homicide death** and the most common type of violence that women experience. At least one-third of New Zealand women (35%) experience physical or sexual intimate partner violence in their lifetime, rising up to more than half (55%) when psychological/emotional abuse is included in the definition. Partner violence can be mutual and men report being victims of physical (14%) and psychological (47.3%) violence in their relationships. Intimate partner violence is associated with physical injury, chronic disorders, pain, and mental health consequences from post-traumatic stress disorder and depression to self-harm and suicide. Non-physical violence, such as controlling behaviour, intimidation, verbal abuse and threats, also causes severe harm, affecting the recipient's physical and mental wellbeing, capacity to work and capacity to parent.

6. **One in four women from New Zealand high-income households** experience physical and/or sexual intimate partner violence in their lifetime; **at least one in ten New Zealand men have experienced childhood sexual abuse**. Reports to police of intimate-partner violence and childhood sexual abuse represent a tiny proportion of what occurs so these are not the rates reported to the police but, rather, have been derived from careful population research and data-gathering.

7. **Early intervention and a life-course approach** (understanding the stages of physical, mental, emotional, social, and cultural development that we all experience) reduce harm in many life domains, including those in which children, exposed to family violence and maltreatment, are at risk of growing up to be likewise involved in violence in their adult relationships and with their own offspring. Holistic, early support for children and families is needed. Having systems that allow more collaboration and cooperation across services to provide early intervention is absolutely vital.

8. **Despite the well-reported relative absence of whānau violence before colonisation, Māori are now highly exposed to it.** The

trauma of colonisation has had an intergenerational effect on Māori, who experience disproportionate rates of family violence, combined with other negative social effects of racism, discrimination and dislocation, alongside strengths and resilience factors that endure. There are iwi-based, local, community and/or NGO solutions that need resources to allow evaluation and scale-up, as appropriate. Programme design, implementation and evaluation must be in accord with a Māori worldview, informed by relevant science.

9. **High rates of family violence in Pacific communities** also need to be tackled by culturally appropriate approaches, with proper understanding of the social and cultural drivers of trauma and discrimination. Engagement with church and community leaders, NGOs and service providers, as well as strategic, national leadership should guide prevention and intervention, employing a culturally skilled workforce in research, evaluation and delivery.

10. **We lack skills and resources to respond to family violence in diverse communities,** including children and adults with disability and LGBTQI people, all of whom can be at risk of family violence and child maltreatment and their consequences. Family violence within migrant and refugee families is under-researched and reflects the complex effects on family dynamics of wider traumatic events and the loss and marginalisation of relocation and acculturation.

11. **Primary prevention initiatives in violence can be relevant** to diverse groups, as long as they are:

    i. strong on fostering networks and partnerships

    ii. well-resourced, tailored to the audience and comprehensive, including addressing underlying stressors

    iii. equipped to deal with disclosure of violence

    iv. able to promote healthy behaviours and appropriately challenge, as well as reinforce, cultural norms

    v. able to promote victim/survivor empathy, i.e., not blaming

    vi. able to include perpetrators as part of the solution, as appropriate.

12. **Reasons for staying in violent relationships are diverse and complex** and may include having come to regard abuse as normal, unequal power and control, shame and secrecy, limited social and financial resources to get away, the need to protect and provide for children, hanging on to hope that things will change, and knowing that leaving may be lethal, including for children. As a community, we need to be better at finding ways to be available, take notice, reach out and help.

13. **Resilience and recovery from the effects of family violence** can emerge as a result of individual characteristics of emotional resilience, building supportive attachments, non-violent role models and wider community support. Increasingly, the child or family's wider environment is seen as the key to resilience – environments cause children to change for the worse, so environments need to be changed for the better, whether this involves more coherent family support, adequately resourced school and specialist input, or other targeted improvements. Also, rather than expecting a child and family to adapt to whatever interventions happen to be available, a coordinated, coherent response – delivered safely and effectively, and for as long as is needed to really stop the violence – is critical.

14. **Prevention of family violence is possible.** International and local evidence shows that family violence can be prevented by wider social understanding of the importance of childhood, thereby reducing all forms of adverse experiences in early life. We need to challenge social norms that relate to violence; not allow economic disadvantage to hamper non-violence; build workforce capacity in prevention and intervention; and enhance support for skilled parenting, quality early childhood care and education, and, where necessary, intervention for individual children and families. Detail on these follows.

15. **We need to understand the importance of childhood and the lifelong, preventable impact of adverse childhood experiences (ACEs).** ACEs include not only family violence and maltreatment but also wider social issues of childhood exposure to alcohol and drug use, food insecurity, homelessness, and parents who are in prison or who cannot get effective psychiatric help. ACEs are key risk factors for physical and mental health issues across the lifespan. ACEs are linked to political, economic and structural violence that result in unequal power and unequal life chances, racial and ethnic disparities, and marginalised children who lack full access to appropriate resources.

16. **We need to change social norms to support positive parenting, healthy relationships and a non-violent New Zealand**. Societal and cultural norms about gender roles, and about what forms of relationships and families are seen as socially acceptable, as well as legal-system responses to family violence, all have a profound impact on how individuals perpetrate or respond to family violence. This includes norms around alcohol and drug use and their links to violence. There is a media focus on victim-blaming and individual service failure, rather than effective violence prevention. There is also a question as to whether, as neighbours and friends, we are willing to engage with people facing – or creating – relationship and parenting challenges. We need to consider the role of awareness-raising campaigns around violence and whether they are adequately supported with resources to help people change.

17. **Research shows that strengthening economic supports for families and "family-friendly" policies are useful.** Family violence occurs at all income levels and in all neighbourhoods. However, having more financial resources can enhance options for leaving a violent relationship or keeping children safe. Financial demands on parenting are high and economic disadvantage increases household stress and reduces access to good housing, healthcare and lifestyle. Good employment is a protective factor and "family-friendly" policies, including flexible schedules, adequate leave and a living wage are associated with lower maltreatment risk. Maltreatment in childhood is associated with poorer economic outcomes as an adult (perpetuating the intergenerational cycle) – so, again, early intervention makes economic sense as well as building better lives and better communities.

18. **Build workforce capacity and capability.** Trauma-informed care has at its centre the voices of children and young people affected by violence and maltreatment, and the voices of partners and parents experiencing violence. Respect, engagement, enduring relationships, a sense of safety, and access to the resources and structures needed to make change are all vital. Many frontline staff know what is needed, but have caseloads that make effective, long-term collaborative work impossible, lost in a welter of short-term crisis management and "one-size-fits-all" interventions.

19. **Enhance parenting support and skills to promote healthy child-development.** Parenting programmes can help break the intergenerational cycle of violence: if violence has primarily been modelled in parenting, it is important to be able to learn other strategies, including how to build attachment, understand stages of child development, and manage emotions and behaviour non-violently. Targeted, evidence-informed, home-based and sustained programmes can help high-risk families. Again, there is a role for us all – when parents feel part of their neighbourhood and community, risk of child abuse is reduced.

20. **Provide quality early childhood care and education.** Early home-based programmes, providing sustained support from pregnancy onwards, are effective in reducing risk of child maltreatment. High-quality early childhood care and education are associated with improved psychosocial outcomes, increased likelihood of experiencing safe and nurturing environments, and lifelong educational benefits, making it highly cost-effective. School engagement is protective for maltreated children and, ideally, the school

community, if resourced to do so, can support access to help and violence prevention. Intervention around a child's early challenging behaviour can reduce the risk of criminal offending.

21. **Intervene to lessen harm and prevent future risk with a trauma-informed approach.** As well as challenging certain social norms and system-wide supports for violence, and making efforts to prevent early harm, we need good interventions for those already harmed. Coherent, collaborative service delivery is needed – at its best, focused on strengths and resilience and away from deficits and blame.

    i. An historical, trauma-informed approach shifts analysis (and therefore judgement) away from asking what is *wrong* with someone to asking what has *happened* to them.

    ii. Interventions range from short to long term and from directly working with a child to bolstering support for the non-abusing caregiver.

    iii. Youth development work focuses positively on a young person's strengths and potential, rather than seeing them as "broken".

    iv. Adults need empowering, advocacy-based help to do safety planning; to counter beliefs that sexual coercion or financial control are "normal" in relationships or that the survivor/ victim is to blame for the violence; and to get referrals for community and therapeutic resources. We need adequate access to culturally appropriate therapeutic and trauma-focused interventions for recovery.

    v. Interventions and support for addictive behaviour are needed – for example, problem drinking is associated with increased risks of intimate partner violence; methamphetamine increases levels of aggression and violence; and problem gambling is an under-researched area associated with parental neglect and abuse, as well as financial and emotional deprivation.

    vi. Interventions with perpetrators need to include co-ordination of support for all involved, crisis response and immediate containment, court proceedings, sentence or order compliance, risk monitoring and behaviour change, and services based on risk and need. As with other offending, deterrence is ineffective - even when in prison, a perpetrator can threaten and harass a partner, or get community associates to do so, if they do not get treatment for change.

    vii. Risk-prediction tools based on data are being developed and there are trials underway, including in New Zealand, using technology to support safety planning, risk prediction, and action.

We do not need to wait for extensive data to know that doing a good assessment - with full awareness of the possibility of family violence and maltreatment - in any situation where a child or family have come to the attention of a community or state agency (e.g., health, education, police, justice) - and having adequate, skilled responses from well-resourced staff, available in a timely manner to deal with this, are critical.

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22. **There can be substantial barriers to implementation of evidence-based prevention and intervention strategies.** Research shows that implementation barriers include lack of community and service-user consultation and engagement, lack of sustained leadership, underfunded services with high staff turnover, lack of training and organisational support to fully implement evidence-based programmes, and changing political, policy and funding climates.

23. **Emerging and promising practice, and diverse research and evaluation methods,** relevant to the social and cultural contexts of diverse families and communities, are needed for research and real-world change to work hand-in-hand. Research funding to grow local knowledge about local needs in family violence and child maltreatment is vital.

Introduction: What can be done to stop violence before it starts?

1. Family violence is clearly a solvable problem. It can be seen as largely a "symptom" of underlying issues, that are indeed multiple and complex, but are the same stressors that drive health inequities, mental-health issues, criminal-justice system overload, education failure, drug and alcohol abuse, social and racial inequality and a myriad social issues. That is, there is much to be gained in the form of unleashing the social and economic wellbeing of New Zealand children, families, communities, businesses, and services if we reduce these harms.

2. On one level, solving family violence and child maltreatment is about common sense:

    i. People should have access to help when they need it (healthcare, trauma recovery, addiction recovery, early intervention to prevent lifelong harm); they need ways to stay healthy (housing, income, food, clothes) and ways to stay involved (jobs, education, social activities, communities and cultures to belong to).

    ii. It's about showing kindness, compassion and thinking of others, in our families, neighbourhoods and communities, knowing that all of us can face hard times, regardless of the resources we have.

    iii. It's about services talking to each other and working together to build a trustworthy, sustained relationship with a troubled child and their family/whānau at the centre (so that child does not have to grow up to be an equally troubled adult), or to ensure adults have the help they need to stop the cycle of violence now.

    iv. It's about having local, accessible, face-to-face support that is promptly available, culturally responsive and evidence-based.

3. So, why does this "common sense" consistently fail to be enacted? In order to act, we have to acknowledge that children of all ages are being badly hurt (emotionally, even if not physically) and that adults who are supposedly in loving relationships are being tormented. It is not pleasant to think about such things, we like to think there's something especially "wrong" with "those people" to make them different from "us". We do not like to think about the journey a child might have taken from being very, very frightened to being very, very frightening (in terms of criminal offending). It's about personalities, politics, power and control issues, lack of leadership, lack of sustainable vision, bad press. Who wants to ask people to consider such matters when we would rather fret about property prices?

4. As reviewed in the first report in this series, New Zealand has a record high prison population even though crime rates have been falling and conviction and sentencing numbers are historically low.[2] [3] Our prison population is proportionally one of the highest in the OECD.[4] We also have one of the highest rates of intimate-partner violence (physical and sexual assault) in the OECD.[5] It can be argued that these two facts are not unrelated.

5. In the second report in this series, the issue of "developmental crime prevention" was outlined; specifically, preventing crime by working on the factors that are associated with the earliest evidence of offending by children and young people. There is strong evidence that interventions are effective for pre-schoolers and young children who are experiencing trauma and maltreatment and who are showing the challenging behaviours that underpin a pathway to offending. There is no doubt that the younger a child is at first intervention, the more effective it is likely to be.[6] [7]

6. As well as intervening early, is it possible to also build forms of *developmental violence prevention;* that is, to more effectively target and prevent the violence and abuse that so strongly underpins many lifelong challenges, including criminal-justice involvement? **What can be done to stop this happening in the first place?**

7. As discussed in the first and second reports, government resources are overwhelmingly directed to those already in the criminal-justice system, albeit with less than adequate consideration of what happens to individuals at the front end – before they enter – as well as for when they leave prison. Far less is directed to preventing entrance into that system. We simply do not act effectively on early signs of harm and risk. This is a waste of human potential and a failure to use science to take action, as a series on global research in the leading scientific publication, *The Lancet,* explains (p. 100): [8]

> *The science is clear and the evidence convincing that our earliest experiences matter … We must draw on this knowledge to take action to support parents, caregivers, and families in providing the nurturing care and protection that young children deserve.*

8. The aim of this discussion paper is to share evidence from science with everyone, because the community is such a crucial piece of the jigsaw of violence prevention in New Zealand. These are two questions to which there are not simple answers, but which all New Zealanders need to be thinking about:

   i. **How can I get involved in evidence-informed action and change?** Rather than this being just another report – there are already many good documents on government and other websites – how can it help people to act? Why is it in a country as small as ours that we fail repeatedly to act on the many recommendations that have been outlined in previous reports?

   ii. **How do we collectively address cultural factors?** How do we stop getting in the way of Māori flourishing? Of Pacific non-violence? How do we build social norms that mean the full spectrum of New Zealanders can have violence-free lives, regardless of their socioeconomic, family or disability status, or their cultural, gender, sexual, social or religious identity?

9. The World Health Organization's public-health approach to addressing violence prevention involves four inter-related steps:

   i. The identification of the nature and extent of the problem;

   ii. The identification of the underlying causes and risk factors;

   iii. The design and testing of interventions that address the underlying causes and risk factors; and

   iv. The scaling up and monitoring of effective interventions by their integration into policies and programmes.[9]

   Such a model could serve as part of a framework for a violence prevention strategy for New Zealand and this paper addresses each of these steps to some degree.

10. Furthermore, a trauma-focused approach is required. For example, that means, instead of asking, "What's wrong with you?", we need to be asking:[10]

   - What has happened to you?
   - How did it affect you?
   - What sense did you make of it?
   - What did you have to do to survive?

11. In this report, definitions of violence and New Zealand rates are first briefly outlined so that we can be on the same page about what the issues are. Then, the impacts on those affected are highlighted. Prevention and intervention at levels ranging from individual to whānau/family, and to communities, organisations, and governments are outlined, followed by discussion of "implementation science" – that is, what gets in the way of implementing effective prevention and intervention strategies. This is not a service audit nor exhaustive literature review; it is a discussion paper for everyone, aimed at raising findings from current science to prompt informed reflection and discussion on the family-violence issues we face as a country and that also underpin many of our criminal-justice problems.

1.1 Violence, abuse, maltreatment and neglect

12. Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[11]

13. This includes neglect, physical, sexual and psychological violence, and can be interpersonal (towards a family member, partner, acquaintance or stranger), self-directed (such as self-harm and suicide), or collective violence, committed by larger groups such as nation states and terrorist organisations and including social, political and economic violence.[11, 12]

14. This *Every 4 minutes* report focuses on interpersonal violence – the many ways that humans in families and communities harm each other. By far the vast majority of violence that occurs in society is committed by those who know the person being harmed. Despite what we might think, it is much less common for violence to be inflicted by strangers. This report uses the overall term "family violence", in line with the New Zealand "Family Violence Death Review Committee",[13] because for some victims, it is only in death that the violence ends.

15. Research and programmes often look at one form of family violence - for example, child sexual abuse or sexual violence by partners – and there is no doubt that it is important to consider specialist needs and responses. The emphasis in this discussion paper, however, is on more generally understanding how the full range of family violence affects children and what we can do to reduce that damage, and – even better – prevent it happening.

16. One issue that has kept coming up in this series of criminal-justice reports is that, although not all those who have been exposed to family violence go on to offend, the vast majority of those who do offend have been exposed to family violence. It is, by far, the most common shared experience of people, at all ages, who are involved in the criminal-justice system.

> **Family violence** is any behaviour that in any way controls or dominates a family member and causes them to fear for their own, or another family member's safety or well-being.
>
> It can include physical, sexual, psychological, emotional or economic abuse and any behaviour that causes a child to hear, witness or otherwise be exposed to the effects of that behaviour.
>
> It can consist of a single act, or a pattern of behaviour amounting to abuse, even if some of the individual acts taken in isolation would be deemed "minor" or "trivial".
>
> It occurs within a wide 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 fulfilling the function of a family.[1]
>
> (This definition is from p.4 of a NZ expert advisory group paper; see the Family and Whānau Violence Legislation Bill www.legislation.govt.nz/bill/government/2017/0247/latest/DLM7159389.html for more technical, legal definitions.)

17. "Family violence" is a broad term that includes child maltreatment, intimate-partner violence, and other forms of violence within families. Some explanations of these terms follow.

18. Firstly, however, it must be noted that the definition of whānau violence is not the same as family violence. There is work ongoing by Māori to agree on definitions to inform action; Te Puni Kōkiri gives a working definition of whānau violence as "the compromise of te ao Māori values [that] can be understood as an absence or disturbance of tikanga and transgressions against

whakapapa" (p. 3[14]), where tikanga is defined as "the process of practising Māori values". Within this definition, "the use of Māori traditional knowledge and cultural practices are fundamental to addressing whānau violence and achieving whānau ora (wellbeing)" (p. 14[15]). Further, Te Puni Kōkiri argues that, "while whānau violence is equated to family violence, Māori responses (and service provision) are constrained by being located within an inappropriate cultural context" (p. 5 [16]; see also *The trauma of colonisation* section below).

19. "Child maltreatment" is a catch-all term, defined by the internationally recognised US Centers for Disease Control and Prevention (CDC) as covering abuse of children that harms them or has the potential to do so:

    - Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child (p. 8).[17]

20. Common types of child maltreatment include:

    - **Physical abuse** is the use of physical force, such as hitting, kicking, shaking, burning, or other shows of force against a child.
    - **Sexual abuse** involves inducing or coercing a child to engage in sexual acts. It includes behaviour such as fondling, penetration, and exposing a child to other sexual activities.
    - **Emotional abuse** refers to behaviour that harms a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
    - **Neglect** is the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, and access to medical care. (p. 8) [17]

21. Worldwide estimates of child maltreatment show that almost one-quarter of adults (22.6%) have suffered physical abuse as a child, 36.3% emotional abuse, 16.3% physical neglect and 11.8% sexual abuse.[18]

22. Maltreatment of children often occurs in the context of abuse and violence between the adults caring for the child who are or have been in an intimate relationship – hence, "intimate partner violence". They may be the child's parents, step-parents or caregivers living in the home with the child or living elsewhere.

23. Intimate partner violence can include verbal abuse, psychological and emotional abuse, sexual assault, financial control and coercion, and/or physical violence, that includes use of weapons or the threat of using weapons, with severity ranging up to extreme, and sometimes ending in death. [19] Intimate partner violence can be at an extreme level without a single incident of physical harm - the stereotype of only physical violence as warranting intervention is deeply misleading (*He's never hit me, so we must be OK.)*

24. "Intrafamilial" violence includes violence amongst siblings, violence by an adult child against their parents, or other abuse/neglect outside of parent/child or intimate partner relationships (uncles, cousins, in-laws etc).[13]

25. This discussion paper does not include detail on elder abuse or violence at work, not because these are not real and of concern, but just because not everything can be covered, and by enacting early intervention with our children and families now, those forms of abuse will also lessen.

Estimated rates of family violence in New Zealand

26. Thousands of New Zealand families and children are exposed to violence and maltreatment every year, or are at high risk of such exposure. In 2016/17, Oranga Tamariki Ministry for Children received 158,921 care and protection notifications, including police family violence referrals, relating to almost 60,000 children (there was often more than one notification per child).[20] Further investigation of 38,975 notifications led to substantiated findings that 14,802 children were abused or neglected last year.

27. There were 121,747 family harm investigations by NZ Police in 2017.[21] That averages out to be nearly 334 every day nationwide, or one every 4-5 minutes. (Since May 2018, NZ Police refer to "family harm investigations" where before the term "family violence" was used. They also have a new Family Harm App, aiming to reduce paperwork and allow relevant, confidential data-gathering on site.)

28. Responding to family violence is time-consuming for police – for example, in the Counties Manukau district, family harm episodes made up 21% of total calls last year but absorbed 40% of officer time.[22] Such call-outs include assessing the risk of potential family violence as well as investigating incidents that may or may not constitute an offence.[23]

29. Family violence may not be directed at a child, but children are affected when exposed to violence in the home. In the second report of this series, the high proportion of youth offenders who had experienced family violence was noted. For example, a review of more than 16,000 New Zealand child and youth offender records since 2013 showed that 80% of child and youth offenders under the age of 17 had evidence of family violence in their homes (and that is just what had been documented).[24] Figure 1 shows that more than 5,000 young children, in just one NZ police district, were exposed to such episodes last year.

30. Furthermore, an estimated 76% of family violence goes unreported, according to the NZ Crime and Safety Survey 2014.[25] (This survey shows that more crime is experienced than is reported overall, but that household offences, such as burglary, vehicle theft etc, are more likely to be reported to police - 38% - than are personal offences, such as intimate partner violence, family assaults etc, which are reported at rates of only 24%.)

31. Alcohol and drugs are reported by police as a factor in at least one-third of family harm investigations; for example, in August 2018, there were 10,982 family harm investigations; 3,351 (31%) were reported as involving alcohol and drug use, with another 895 where alcohol/drug use could have been a factor (taking the total to 38%). Consistent recording of alcohol and drug use in relation to family harm began in June 2018.[21]

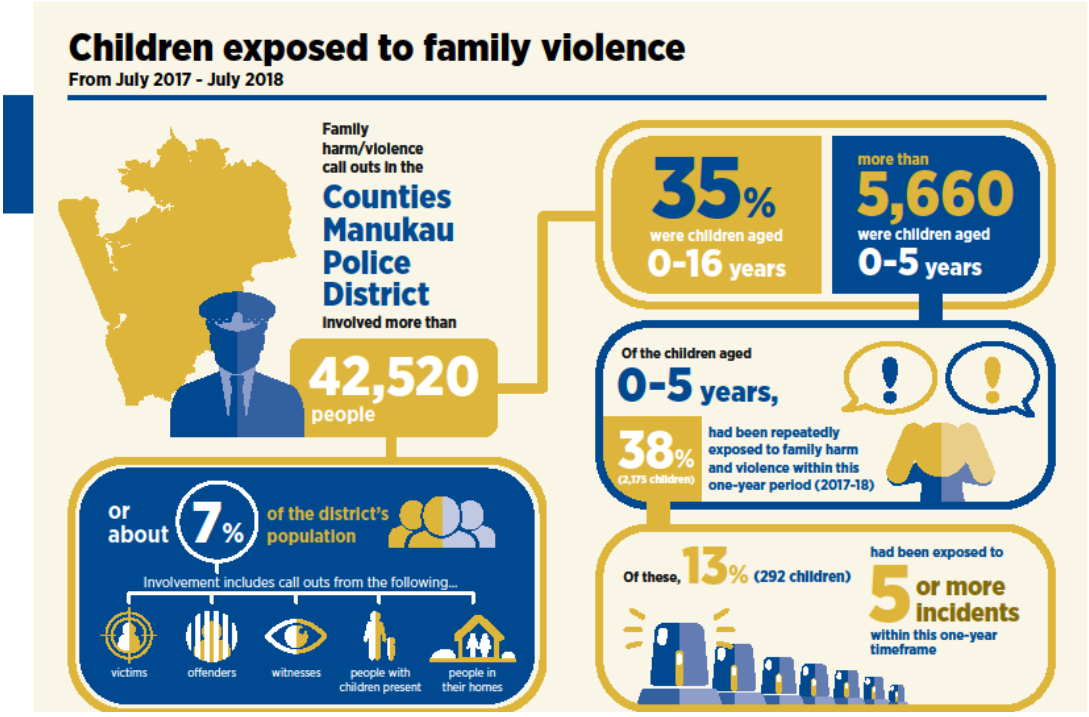

FIGURE 1. EXPOSING CHILDREN TO FAMILY VIOLENCE

The family harm statistics presented here were derived from available operational data and should be considered provisional. These statistics are not comparable with official statistics published by Police elsewhere.

32. The Ministry of Justice points out that "family violence offending can be covered by a range of different offence types that are not easily identifiable as involving family violence" (such as homicide, for example). [26] The Ministry uses three offence types to represent family violence – breach of protection order, common assault (domestic) and male assaults female. This is acknowledged as an underestimation: "These three offence types represent approximately 50% of all offences related to family violence in court each year."[26]

33. Most people convicted of the three family violence offences in 2017/2018 were male: that is, 93% of people convicted of at least one of breach of protection order, common assault (domestic) or male assaults female were male.[27]

34. The vast majority of applications for protection orders are made by women, with 5,072 (89%) made by women, and 10% (550) by men. The "respondents" (that is, the person receiving the order) were mostly men (4,940 or 89%), with 10% (560) directed at women.[28] In 2018, there were 71 women and 2,391 men convicted of the offence of breaching a protection order.[27]

35. Intimate partner violence, including physical, sexual, and/or emotional violence from a partner or ex-partner, is the most common type of violence that women experience. [29] Worldwide, 30% of women (15 years old and over) have experienced such violence in their lifetime.[30] In US data, both men (14%) and women (23%) report rates of severe physical violence by an intimate partner in their lifetime, and nearly half of US men and women report experiencing psychological aggression from an intimate partner.[31]

36. Similarly, at least one-third of New Zealand women (35%) experience physical and/or sexual intimate partner violence in their lifetime. [32] When psychological/emotional abuse is included in the definition, more than half of women (55%) reported experience of intimate partner violence.[32] (These are not rates reported to the police, but calculated through population research and data-gathering; reports of intimate partner violence to police represent a small proportion of what occurs.) In New Zealand longitudinal population studies, both men and women were psychologically and physically aggressive to their partners, according to self-report scales used with Dunedin 21-year-olds[33] and Christchurch 25-year-olds [34] who were dating or married. More of the 21-year-old women (28.5%) than the young men (20.7%) reported having "pushed, slapped, or shoved" a partner, but the researchers noted that, in these early studies, the injury rates, degree of coercive control, intimidation or frequency of these actions were not reported[35] nor the contexts of how a "slap" or "shove" may differ in impact between men and women as perpetrators and victims.[36]

37. Those who have experienced sexual or physical violence by an intimate partner in their lifetime include 1 in 4 women from New Zealand households with incomes over $100,000, and 1 in 4 had university degrees.[37]

38. Ninety-two women died because of intimate partner violence and 52 children died as a result of child abuse and neglect in New Zealand between 2009 and 2015.[38]

39. Between one in three [39] and one in five [40] women, and one in ten[39] men, report having experienced childhood sexual abuse. Māori women report higher rates than do non-Māori.

40. Police recorded 2,207 sexual assaults on children under 16 in 2017. Police recorded 765 assaults on children aged under 16 perpetrated by a family member.[21]

The challenge of data-gathering

41. Although these numbers give some sense of the scale of family violence and child maltreatment, they by no means capture the full picture. Data are hard to gather and, in New Zealand, there is not a single agency responsible for doing so. [41] Police call-outs and child-welfare notifications provide some data but are known to be under-representations of what occurs; community, self-report scales capture rates of mutual couple conflict[42] but lack details of frequency and impact.[43] [44]

42. By their nature, these crimes occur in private; young children are powerless to speak out when dependent on and threatened by violent adults; and intimate partnership violence involves complex issues of power and control. Definitions of what is being measured vary; there are changes over time in reporting practices and data systems within police, child welfare, health and other services; and there are social and political changes in how much these issues count – and are counted.

43. To understand likely rates of family violence, official statistics are used (e.g., from police and child-welfare services), which capture the minority that involve such authorities. Then, there is research with the general population; that is, people who are not part of the "official" reporting systems of police and child-welfare, but who may nevertheless be experiencing – or have experienced – maltreatment, whether in their own childhoods or as adults with family members, former or current partners. Two sources of such data include the NZ Crime & Safety Survey, and population research replicating World Health Organization (WHO) research methods:

- The NZ Crime and Safety Survey (NZCASS) was conducted from time-to-time (2006, 2009 and last reported in 2014).[45] The new survey, NZ Crime and Victims Survey (NZCVS), is currently being analysed (so data are not yet available). This allows a randomised sample of 8000 New Zealanders to answer about many types of crime, that may or may not have been reported to police, to track crime trends (starting from 2018), information about victims and non-reporting. Relevant questions are on partner violence (assaults, threats of assault, damage or threats of damage to personal property, coercive and controlling behaviour); violence by people well-known (ex-partners, family members, others well-known); and sexual violence (rape, attempted rape, distressing sexual touching, and other sexual violence or threats).
- The WHO multi-country study methodology for collection of data on violence against women is seen as rigorous and safe (e.g., recruiting randomised participants to research on "women's health" rather than "violence" per se, conducted confidentially without partners present, etc). [46] [47] This was used in NZ in 2003, so figures are valid but most likely an under-estimation. [48] [49]

44. In addition, what a "family violence" notification means to any of the family members involved will also vary greatly, as will what level of "intimate partner violence" will be endured by one person or reported by the next. As well as addressing the challenges of gathering statistics about family violence and child maltreatment, "qualitative" research (so-called to distinguish it from "quantitative", statistically focused research) is crucial. This is where the experiences and voices of those affected are seen as valid data to guide intervention and prevention. The "experts" on violence are all those who have been living with it – or learning how not to - as these Australian researchers point out (p. 13):[50]

> *There is much that statistical data cannot tell us; for example, about how violence is experienced and understood by victims, or why some people take up violent behaviour and others do not. The use of statistical data, together with qualitative research studies, provides a fuller picture of the nature of domestic and family violence, such as its gender dynamics, its secrecy, and the shame and fear which lie behind the figures.*

The trauma of colonisation and prejudice

45. Māori have disproportionate rates of family violence and face higher rates of criminal victimisation. [51] Intimate partner violence rates are decreasing, but 11% of Māori are still likely to experience a violent interpersonal offence by an intimate partner (compared to 5% of the general population).[51]

46. Te Puni Kōkiri note risk factors such as lower median annual income, youthful population (42% of mothers who gave birth in 2016 were aged under 24 years, often in single-parent households), and higher rates of psychological distress and hazardous drinking in adults. They also note, however, rising resilience factors such as education (81% of 18-year-olds have NCEA Level 2/equivalent), whānau wellbeing (a majority reported they could get help from their family) and cultural wellbeing (with two-thirds knowing their ancestral marae).[51]

47. The trauma and losses associated with colonisation have continuing impacts over generations, increasingly appreciated as a contributor to the intergenerational transmission of trauma.[52] There is historical evidence of respectful whānau relationships, collective obligations and responsibilities, including for the care and protection of children (and their mothers), and the absence of violence within whānau, prior to colonisation. [53] Therefore, culturally appropriate support tailored to whānau history, building safe and supportive communities, and restoring and reconnecting with cultural identity are seen as vital to transforming whānau affected by violence.[53]

While trauma is an experience that can impact on all people, Māori experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health.[54]

48. There are iwi-based, local, community and NGO solutions that need resources to evaluate and scale up where appropriate.[55] Te Puni Kōkiri has analysed the lack of development of robust evidence for approaches based on culturally appropriate frameworks,[56] as was noted in the first two reports in this series. They call for programmes that are shown to be effective being implemented to suit local contexts, with a particular focus on four key aspects: "hard to reach" whānau/communities; citizen/whānau-centred services and interventions (consistent with Whānau Ora); policy and practice tackling community and systemic factors; and a flexible funding approach.

49. There is disillusionment with notions of "responsiveness and inclusiveness" in policy when, in practice, there is seen to be "the continued application of Western-privileged frames" (p. 40), [57] in particular when evaluating programmes (which has a material impact on funding). [58] Instead, programme design, implementation and evaluation must be in accord with a Māori worldview, and our obligations under the Treaty of Waitangi.

50. To quote a multi-agency, justice-sector discussion paper on Māori justice outcomes,[59] "We need a strategic approach that combines the complementary strengths of iwi/Māori and government. Core to this is a *meaningful partnership"* (p. 6). Such a partnership, that is an interdependent, kaupapa Māori approach, needs to be leading this work.[60] [61] This includes in interventions with Māori children seen to need care-and-protection by the state, with an evaluated trial of Iwi Advisors (effectively, legal navigators for whānau) concluding that, "Māori must be part of the solution if we are ever to reduce the number of Māori children in care" (p. 26) [62] and expressing ongoing concern that Oranga Tamariki changes may not go far enough towards this.

51. There are also high rates of family violence in Pacific communities and we must support cultural leadership of appropriate interventions to address family violence in these communities.[63] As noted in the second

report in this series on youth offending, interventions continue to be sourced from Western worldview models of theory and practice, despite there being wide-ranging recommendations from within different cultures as to how to approach the issues. For example, a Samoan report on preventing family violence against women called for fa'a Samoa principles to be enacted; warned that violence must be tackled with understanding of its social and cultural drivers in context; and that communities - if listened to - know what does and does not work.[64] The starting point is to have some honest conversations between all stakeholders.

52. There is growing information in areas such as education and health that shows that a more culturally targeted approach and intervention is needed when working with Pacific people; this applies to those in the child-welfare and family-violence system. Appropriate cultural engagement is vital, from communities and church groups, from NGOs and service providers, and from strategic, national leadership, as are appropriate research methods and interventions delivered by a culturally skilled workforce.

53. Family violence within refugee or migrant families is under-researched and the diversity of experiences of different cultures and journeys to resettlement mean that responses need to be appropriately targeted. [65] [66] We need to be aware of parental trauma and distress; how these affect family dynamics and relationships; and result in the silencing and denial of past traumatic events, high levels of post-traumatic stress disorder (PTSD) and depression. Acculturation stress, including culture clashes around gender roles or childrearing practices, for example, and marginalisation, racism, loss of status and employment can all contribute to risk. There can be family-resilience and cultural factors (including spiritual beliefs) that are protective. There is a need for a culturally competent approach to trauma, including both family-based and individual support, that is sensitive to cultural issues but nevertheless ensures that family and intimate partner violence are addressed.[67]

54. There is an even greater risk that prejudice and lack of skill will mar the response to children and adults with disability [68] and LGBTQI people,[69] who can, of course, also experience family violence and child maltreatment and their consequences.

55. Successful primary prevention initiatives in violence can be relevant to a wide variety of cultures and communities,[60] as long as they are:

    - strong on fostering networks and partnerships
    - well-resourced, tailored to the audience and comprehensive
    - equipped to deal with disclosure of violence
    - able to promote healthy behaviours and challenge cultural norms
    - able to promote victim empathy, i.e., not blaming
    - able to include [perpetrators], as part of the solution. (p. 6).[64]

1.2 The impact of trauma

56. The word "trauma" (literally from the 17th century Greek for "wound") has long been used in medicine for physical injury (e.g., "blunt-force trauma"). It is now widely used in relation to emotional and psychological harm, of the type that often results from family violence. Trauma is an overused term, sometimes just meaning "an emotional upset".[70] In relation to family violence, the term "trauma" is more often defined as "a deeply distressing or disturbing experience"[71] or "a disordered psychic or behavioural state resulting from severe mental or emotional stress or physical injury".[70] It is also used in relation to forms of intervention, namely "trauma-informed care" which is discussed later in this paper.

57. This section considers the impact that trauma can have. New Zealand's high rates of family violence and child maltreatment are associated with outcomes ranging from mental-health problems and psychiatric disorders, to physical-health problems such

as heart disease, brain injury and neurodevelopmental issues, to many behavioural and social problems, including substance abuse, antisocial behaviour, poor educational and employment outcomes, and criminal offending. Adult exposure to intimate partner violence makes it harder to parent, and there can be an intergenerational risk of childhood victims and witnesses of violence becoming involved in violence in adulthood.

Stress in action

*When you are driving your car and have a "near miss", you most likely swear and swerve, your heart races, your temperature rises, your stomach churns and you may feel shaky. You keep driving, hyper-alert for the next ***!!@ who is going to drive equally badly, and you shout at the kids to shut up in the back. Or, perhaps you pull over to calm down, take a few deep breaths, and feel glad to be alive. If you were asked at this moment to solve a maths problem, you would be useless – your brain is scrambled onto "danger" and "alert" mode and your system is flooded with stress hormones. You'll be curiously exhausted tonight but not manage to sleep very well.*

How much more does all this apply when you are a child, totally dependent on adults with whom you have to remain but who frighten you sometimes, even though they seem to be kind to you at other times. How do you ever calm down? How do you focus at school? How do you get to sleep?

58. Stress is a normal human reaction that we all experience in response to a threat. It can be a threat of any kind ranging from a scary dog, to a car crash, loss of a job, death of someone close, or an earthquake. Stress involves both a psychological and a biological response. It is our body that decides our response to the stress and is based upon how our senses respond (i.e., hearing, seeing, balance, etc.) and also our stored memories. Typically, people might either fight, flight or freeze. A number of chemicals get released by our body, one of which is cortisol which is released to maintain good supplies of sugar. However, if the stress is continuous - as is the case in child maltreatment and family violence - cortisol remains at high levels for extended periods of time; this has been shown to have negative effects on health, increasing the risk of high blood pressure and decreasing immune responsiveness.

Impacts of family violence and abuse on children

59. Exposure to family violence has substantial impact. The chronic stress a child feels when exposed to abuse and violence has effects on all the body's systems (such as the nervous, immune, and metabolic systems), resulting in increased risks of poor physical health throughout life.[72] Child maltreatment is also being linked to epigenetic changes (epigenetic signals regulate gene expression and are being shown to be sensitive to early negative environments, resulting in molecular changes that affect us mentally and physically).[73] "Toxic stress" results from chronic exposure to maltreatment and violence in infancy, affecting cortisol levels and the architecture of the brain, and associated with biological changes in the developing body and brain, negatively affecting childhood and long-term physical and psychosocial health, through upsetting the neuroendocrine and immune systems, and brain development critical for learning & memory.[74] [75]As this adult explains (p. 16): [64]

> *I think nothing could replace the fear that I felt as a youngster going home every day because of the violence that took place in our house, and every time you try to do something it just got even worse.*

60. Children exposed to family violence are likely to experience increased levels of behavioural and mental health issues, including externalising, internalising, and adjustment problems. Externalising behaviours are characterised by aggression, violence, conduct problems and attention deficit hyperactivity disorder (ADHD), whereas internalising problems are characterised by anxiety, depression, self-harm etc. Moreover, the negative effects of exposure to family

violence are cumulative – the stress keeps adding up and compounding. Similarly, those who are exposed to a greater range of physical, emotional or sexual violence experience worse outcomes.[76]

61. Child sexual abuse has significant long-term impact. A New Zealand longitudinal study indicates that those with a history of childhood sexual abuse, compared to those without such a history, had higher rates of psychological disorders, suicidal thoughts and attempts, substance dependence, risky sexual behaviour, welfare dependence and contact with medical professionals due to physical-health problems, and lower rates of self-esteem and life satisfaction at age 26 follow-up.[77]

62. Children who have been abused are at higher risk of involvement in the criminal-justice system: exposure to trauma (whether physical abuse, sexual abuse, maltreatment, neglect, violence, emotional and/or psychological abuse) is a key factor in producing higher rates of offending behaviour. Persistent maltreatment is linked to later violent offending[78] and those who have experienced recurrent maltreatment or more than one form of maltreatment are more likely to engage in offending behaviour.[79]

63. Research shows that 13% of maltreated children and young people in the child-welfare system in Canada had documented aggressive behaviour (including towards other children or adults, or violent property damage at home, school or in the community), compared to population rates of less than 1% to 4%.[80] Adolescents with a history of maltreatment were also more likely to be involved in the youth-justice system (6%), compared to population rates of less than 1%.

64. As noted, in New Zealand, most (87%) young offenders aged 14 to 16 years old in 2016/17 had had prior reports of care-and-protection concerns made to Oranga Tamariki (86% males, 92% females),[81] indicating the pathways from childhood maltreatment to antisocial behaviour.

65. Research has also shown that those who engage in aggressive and criminal behaviour have experienced more severe and co-occurring forms of maltreatment in childhood than their non-aggressive counterparts, and there can be evidence of their vulnerability as early as age 3 or 4.[80][82] Early physical abuse, in particular, has been associated with later aggression, and researchers suggested this was probably due to the impact of such abuse on how well children are able to process social information and read social cues; they are more likely to quickly attribute hostile intentions to others; and are less skilled at problem-solving. (Fairly obviously, being punched and hit does not model how to negotiate and resolve problems in other ways.) In addition, aggressive adolescents were more likely to have been abandoned by their caregivers, unable or unwilling to deal with them, putting them at risk of neglect, homelessness and further risks.[80]

66. Self-reports from New Zealand youth offenders in secure youth-justice facilities indicated that, on average, both males and females had experienced at least two traumatic events, including (but not limited to) being raped, sexually abused or being in danger of being sexually abused; being badly hurt or in danger of being badly injured or killed; witnessing someone else being severely injured or killed; or experiencing another event that was subjectively terrifying.[83]

67. Offending patterns among youth with a history of out-of-home-care are more likely to be chronic and persistent into adulthood[84][85] - a "history of out-of-home care" is jargon for the child having been removed from the adults with whom he or she was living because of family violence (the most common reason) or risk of harm.

68. Poor school engagement and attendance are risk factors for criminal-justice involvement and are also related to child maltreatment. Children experiencing maltreatment or exposed to family violence are at greater risk of finding school difficult (emotionally, socially and cognitively).[86] Keeping them engaged with school can, however, provide a

buffer against long-term learning problems and can give them a sense of consistency, security and support, especially where schools understand the impact of trauma on learning and behaviour.[86] It can be difficult for caregivers who are themselves surviving – or living with - violence to ensure children are getting to school or attending to learning activities; parents who perpetrate violence may no longer care.

69. Furthermore, when children are absent from school, the risks of engaging in offending or with antisocial peers increase, with research showing that school absenteeism was associated with the highest risks of criminal-justice involvement for children and youth involved in child-welfare services.[86]

70. The costs and impacts of childhood trauma go on to adulthood, but are complex to measure and define. For example, Australian estimates were of a collective cost of AUS$9.1 billion from the impacts of unresolved childhood trauma and abuse of more than five million Australian adults.[87] In New Zealand, figures were calculated by Treasury in 2006 (but not since) in terms of quality-adjusted life years (QALYs) based on estimated losses associated with broken bones, miscarriage, anxiety, time off work and so on, for violent offences ($2.77 billion) and sexual offences ($1.19 billion).[88] These are not separated into family and other forms of violence. In 2014, cost estimates specifically for child abuse and intimate partner violence ranged from $4.1 to $7 billion, based on pain, suffering and premature mortality of victims, health costs, productivity-related costs, and administrative costs including police, court system, incarceration etc.[89]

Child and adolescent mental-health and developmental disorders

71. Family violence has been shown to predict increased child anxiety and trauma symptoms.[90] Studies indicate that children from families reported to child abuse and neglect agencies have high rates of post-traumatic stress symptoms. The prevalence of post-traumatic stress was higher for children in out-of-home care than for those who lived at home.[91]

72. There are high rates of post-traumatic stress disorder (PTSD) as a result of child maltreatment in young-offender populations, with girls in juvenile detention centres significantly more likely to have PTSD than boys[92] (40% and 17% respectively[93] - with the proviso that boys are less likely to report).

73. Individuals who have experienced abuse and trauma earlier in their lives have neurophysiological differences and are less able to regulate their emotions, as well as tending to act more aggressively;[94] anger and aggression are highly correlated with violent crime.[79] Aggressive behaviour and poor emotional regulation was already evident by age 3 in research with infants who had experienced more than one adverse childhood experience (such as physical or emotional abuse or neglect, sexual abuse, household substance abuse, having an incarcerated household member, family violence, conflictual parental separation and divorce, and/or poorly managed parental mental illness).[74]

74. Neuroimaging of brain development shows that the brains of maltreated children are changed by their trauma. Brain changes may be adaptive to help them survive[95] – in simple terms, for example, those experiencing verbal abuse may have changes in their auditory cortex (so affecting their processing of sound);[96] those witnessing parental violence can have visual cortex changes;[97] and those being sexually abused, sensory cortex changes.[95] However, even though the changes are well-described in general, such specific mapping of subtypes of abuse onto brain damage or adaptation remains inconclusive.[98] It is also still hard to know exactly when – in cognitive or emotional development – the greatest sensitivity to harm occurs or how it is that brain changes are associated with adult psychiatric problems for some people and not for others.[95]

75. Research is also showing the "long and complex reach" of early childhood adversity in negatively affecting mental health far into adulthood, both directly (e.g., through persistently experiencing depression, anxiety

and PTSD), and indirectly (e.g., through negatively affecting school outcomes and thus employment prospects, or damaging interpersonal skills and thus social support and relationships in adulthood).[99] It has been found that there are high rates of mental-health problems among men arrested for domestic violence, particularly PTSD and depression [100] (presumably associated with their own history of maltreatment – see *Victim-offender cycle* section).

76. There is emerging evidence that early life adversity affects our very DNA, with research support growing for an environmental epigenetics hypothesis, where early life adversity is associated with epigenetic modifications such as DNA methylation. This is being shown in research with adolescents known to have been institutionalised in infancy, or to have experienced severe lack of parental care in childhood, and is thought to biologically affect the individual's capacity to manage stress and possible links to psychiatric illness, but more research is needed.[101]

Exposure to intimate partner violence

77. Intimate partner violence is associated with serious physical and mental health consequences.[102] It is the leading cause of female homicide death.[103] Justice-system reported data and deaths feature men hurting and killing women;[104] [105] there are also women who assault their male partners;[106] and there is also violence in LGBTQI partnerships.[107] There are research debates about gender differences and mutual partner aggression in terms of samples used (e.g., young couples dating vs. married/partnered with children). For example, while dating, men report more physical victimisation by women; in marriages, women are reported to be more often victimised.[108] In clinical or justice-involved couples, the violence may be more severe, involving more women reporting injury, than that reported in non-clinical samples;[109] in community and population samples, research includes more mutual "situational couple violence" perpetration by both men and women.[110] Physical violence is measured most often; emotional, economic and sexual abuse in intimate partnerships are less adequately represented in research.[111]

78. Mental wellbeing is harmed by intimate partner violence. Research shows that those experiencing intimate partner violence are at substantial risk of mental health issues, in particular depression, anxiety and post-traumatic stress disorder (PTSD).[112] In a community sample of women affected by intimate partner violence, the majority met criteria for PTSD.[113] There are also increased rates of self-harm, sleep disorders and suicide.[30, 102]

79. Intimate partner violence is also associated with multiple physical-health impacts, including soft-tissue and musculoskeletal injuries, poor functional health, chronic disorders, chronic pain, gynaecological and pregnancy problems and loss, and increased risk of STIs.[102]

80. The violence does not have to be physical to cause severe harm: psychological violence, such as intimidation, verbal abuse, controlling behaviour, and threats, has also been shown to significantly impact mental health outcomes.[112]

81. Obviously, directly abusive behaviour from adults has a negative impact on children. But being exposed to parents' intimate partner violence – even when none is specifically directed at the child – also has been shown to have severe negative effects. Being exposed to intimate partner violence in childhood is a risk factor for being a perpetrator of such violence in adulthood, but mechanisms are poorly understood, and the theoretical and cultural frameworks of such links poorly articulated.[114] The associations between childhood exposure and adult perpetration vary by gender – of the child, the perpetrator and the non-abusive caregiver – and also by whether the individual has experienced other forms of childhood maltreatment.[114]

82. A recent review highlighted the over-emphasis on individual risk factors for the intergenerational transmission of intimate partner violence, without sufficient understanding of the wider social and cultural

norms around gender, sex, relationships and violence.[114] For example, in a study of 28 countries, a key risk factor for all forms of child abuse was positive parental attitudes towards "corporal" (i.e., physical) punishment of children. [115] Societal and cultural norms about gender roles and responsibilities in relationships, socially "acceptable" forms of partnerships and families, and legal-system responses to family violence vary widely and have a profound impact on how individuals enact or respond to family violence.[114]

Effects on parenting

83. Parenting is affected by family violence.[116] A recent review found that intimate partner violence is associated with a range of deleterious effects on parenting, including less use of positive parenting behaviour, such as warmth and engagement, more risk of neglect and more use of physical aggression and authoritarian parenting styles. [117] All parents know that when they are highly stressed, they are less likely to parent as well as they might prefer; a parent exposed to family violence is understandably often highly stressed.[118] [119]

84. Research indicates that maternal warmth, limit-setting abilities, and improved maternal mental health may mediate the onset of internalising (e.g., depression) and externalising (e.g., aggression) problems in children exposed to family violence;[120] thus, timely provision of community support for mothers and babies can have a positive impact.

The victim-offender cycle: Why does violence lead to violence?

85. As was noted in the second science advisors' justice report,[121] by far the vast majority of all offenders in the criminal-justice system are victims themselves, having experienced high rates of criminal abuse, neglect, and violence, often from infancy. Intergenerationally, they are much more likely to also have parents and grandparents who have experienced chronic victimisation. However, intergenerational violence is not inevitable – the cycle can be broken.

86. We also understand how we all learn behaviours from those who care for us as young children and that this pattern of behaviours influences us for the rest of our lives. This is how we learn to cross the road safely, how to clean our teeth, how to behave, and how to treat others and ourselves. It can include learning behaviours that are violent. Despite what we might think, research shows that it is extremely hard to change behaviour, despite our very best efforts. (Think about a time you embarked on an exercise programme or vowed to eat more vegetables.)

87. A large body of research supports a theory of intergenerational transmission of violence that posits that children exposed to family violence are more likely to become perpetrators or victims of violence in adulthood.[122, 123] For example, New Zealand research strongly indicated that both direct and indirect exposure to violence in childhood was associated with an increased likelihood of intimate partner violence. [124] That is, if both partners had been abused as children themselves, and both had seen their parents being violent, the odds were increased that their adult relationships would be violent.

88. Similarly, child maltreatment in one generation is related to maltreatment in the next generation.[125] [126] There are increasingly well-understood biological and environmental pathways involved. Safe, stable, nurturing relationships outside the caregiver-child dyad (e.g., partner, co-parent, or adult social-support resource) can have a positive impact on decreasing inter-generational maltreatment.[126] It is never too late to help people abandon destructive behaviours and adopt nurturing ones.

89. Exposure to family violence has been found to be the best predictor of adolescent males' aggression and violence and female victimisation in intimate relationships. [127] Indeed, a recent longitudinal study of nearly 500 youth found that harsh parental discipline and interpersonal parental violence predicted perpetration of dating violence.[128]

90. Similarly, a large longitudinal study found that adolescents who had been maltreated in childhood went on to display higher rates of intimate partner violence than controls,[123] indicating how children and young people can learn that violence is an acceptable form of interaction in relationships.[129, 130] In other research, boys exposed to intimate partner violence by age 12 held more pro-violence attitudes by age 15 and were engaged in more antisocial behaviour by age 17 than those who had not lived with such violence.[131] As a former perpetrator explained (p. 17):[64]

> *I tried hard to be a good man but unfortunately no one ever told me what a good man looked like, what a good man does. Because all the men that I've known in my life all perpetuated violence and that's all I knew.*

91. There is also evidence of intergenerational transmission of neglect, with parental experience of neglect or abuse being seen as a risk factor for a child to experience neglect.[132] Neglect is not as well researched as other forms of child maltreatment, despite being widespread and, like other forms of childhood adversity, having a negative effect on brain development.

92. The intergenerational transmission of violence is not inevitable, however, though more research is required to identify the factors that prevent vulnerable children from growing up to become perpetrators or victims of violence,[133] as well as the wider contexts in which each generation is located. For example, higher perceived social support by new mothers after giving birth reduced the risk of maltreatment for their offspring up to 8 years later, even when they had experienced childhood violence themselves; this is encouraging.[134] However, the social support had little effect if the mother remained in an abusive relationship following the birth; this indicates that there is more to do. Also, an involved father or father figure for 9- to 10-year-olds (who had experienced maltreatment) reduced the likelihood that that child would go on to perpetrate violence as an adult.[134] Do we offer to engage with other people's children enough?

93. As discussed in the second report in this series, we need to break the victim-offender cycle by developmental crime prevention, where we prevent crime by working on the factors that are associated with people starting to offend.[135] New Zealand's longitudinal studies of human development (such as the 1000 babies in Dunedin born more than 40 years ago) have had data gathered about their experiences and behaviour, and these show clear links between violence and abuse in childhood (documented via medical and social-welfare records, and study data) and subsequent effects on mental, physical and social wellbeing, including ongoing involvement with violence and crime, or evidence of how this cycle is changed.[136]

Case study: Breaking the cycle

A mother with young children has a history of abuse by family members as a child and has experienced lifelong exposure to family violence. She felt unsafe within her family and moved to live on the streets at a young age, at which point she also stopped attending school. She reports lifelong judgement, and failures by services to support her. She has previously managed her trauma through self-harm and alcohol and other drug use. Through a trusted relationship and support, she is now proactively participating in mental health and trauma support for herself and for her children, who have also witnessed violence. Her children are also receiving early intervention support for behavioural challenges.

Why do people stay in violent relationships?

94. Many people find it difficult to understand why those being harmed by partners do not "just end the relationship". In particular, there can be a sense of judgement about parents with children who do not take children away from a violent partner or parent. Such judgement extends from community members to service providers, as New Zealand research noted (p. 33):[137]

When people are seeking help or are identified as being victims of family violence, the accurate documentation of their story is also fraught – they are frequently forced to retell their stories to different people, are not believed, and their stories are misinterpreted. Generally the focus has been on women who are victims and holding them responsible for keeping themselves and their children safe and questioning what they are doing about the violence in their lives - while the person using the violence is rendered invisible.

I had to leave because I did not see the situation getting any better, and cause I did not see his family's attitude changing around violence . . . because when it happened, the family knew that he had hit me and they had never done anything to challenge my husband about why he's doing it and, if they talked amongst themselves, I'm quite confident that they believed that I deserved to be hit, that it was my fault…. I wanted my marriage to work, I thought it was going to be different the next time, and the promises that go with it.

95. Reasons for staying in violent relationships are diverse and complex. Intimate partner violence does not necessarily start on the first date – or even in the first years of a relationship. A gradual process emerges of undermining confidence, taking charge of all decisions and financial resources (so that having one's own money to get away is impossible), and isolating the person from friends and family. In-depth interviews with women who had had a violent partner identified that leaving the relationship was associated with considerable risk, including children's safety, economic hardship, lack of safe housing, and fear of retaliatory violence. Such risks often outweigh the benefits of leaving an abusive relationship.[138]

96. Further reasons for staying that have been identified by research include having hope for the future, feeling positive towards one's abusive partner and finding justifications for their abusive behaviour.[139] *Oh, they've just had a bit much to drink. They've been having a hard time lately. I know deep down they love me. I can help them change*. Limited social and financial resources, cultural/ religious and parenting concerns, normalisation of abuse, and shame also make people stay.[139] As this woman explains:

97. There is often a "lose-lose" situation, whereby both staying with the abuser and leaving risks further harm to themselves and often their children.[140] A key factor underlying the decision to stay or leave is thus minimisation of harm. When the risk of harm outweighs the perceived benefit of leaving, and particularly when there is risk to the safety of children, women often feel forced to stay in abusive relationships.[138]

98. Leaving can be lethal – according to the NZ Family Violence Death Review report, two-thirds of the female victims were killed, or their new male partners were killed, by the aggressive partner in the time leading up to or just after separation.[13] The review also found that most women who had been killed had previously disclosed the violence and asked for help – further highlighting how it is the responsibility of us all to respond.

99. There can also be a lot of misunderstanding about whether women in abusive relationships do – or should – "fight back", and whether this would help to end the violence or make it worse. In research interviews with New Zealand women who had experienced physical violence from a male partner, more than two-thirds reported that they had never used physical violence against him and just under a third had used it once or twice in the context of a violent episode.[141] This is in line with research showing that one of the most common reasons for women using violence is for self-defence.[142] If a child was present when the violence was taking place, the woman was

more than five times more likely to use violence, which is in keeping with other research findings that women may use violence in an attempt to protect their children.[142] Most (66%) of the women who reported fighting back found that the violence did not reduce nor stop, as other research has reported.[143]

100. Unfortunately, people's perception of those who stay in abusive relationships is often characterised by blame.[139] This is despite awareness-raising campaigns about family violence that urge families, friends, neighbours and community members to reach out and help, rather than judge, such as New Zealand's *It's not OK* campaign. Developing support systems and mobilising them have been described as central to getting away – and staying away. [144]

1.3 Social prevention is needed

101. In this section, the concept of "resilience" is briefly covered – why do some people survive the experience of family violence with fewer negative effects than do others? Then, the focus is on action that we can take to prevent family violence. As the title of this section indicates, it is crucial that we not only focus on early intervention and programmes that help parents, families/whānau and children recover and change**. Social prevention** is needed, in that these individual and family problems occur in our neighbourhoods and communities, within social and cultural frameworks and within political and economic structures. This section therefore explores recommendations for action, from individual to social change, and asks about the barriers, within our communities and systems, to intervention and action.

102. It goes without saying that early intervention is needed. If unaddressed, problems in early childhood may become life-course-persistent. [145, 146] There is strong evidence that interventions for children are effective and, crucially, that the younger the child is at intervention, the more effective it is likely to be.[147] [148] Evidence-informed early action with children and families is also preventive (in terms of breaking intergenerational cycles of violence and abuse). Please refer to the second report[121] which focused on early intervention in terms of "developmental crime prevention" – the programmes that help to address the severely challenging behaviour of children that sets them on a pathway to offending, also help to address the effects of family violence, child abuse and neglect that characterise that pathway.

Resilience

103. More research is needed to better understand the reasons why some adults and children are more resilient to the detrimental impact of family violence than others,[149] [150]as exposure to family violence does not result in the same negative, short or long-term consequences for all.[151]

104. Resilience (the ability to "bounce back" from adversity) may relate to individual differences including how different genetic factors, IQ, gender, biological sensitivity or emotional processes in a child affect how harmed they are by violence; there is ongoing research on the impact of various individual features on different outcomes. For example, having an "easy" temperament,[151] or good emotional regulation and prosocial communication skills may be particular protective factors.[152]

105. More obviously, family factors have consistently been associated with resilience following exposure to child maltreatment, such as a stable home environment and supportive relationships.[153] Having a secure attachment to a non-violent caregiver, particularly the child's mother, is protective[120] and non-violent role models and people offering support within the wider family or community have also been identified as important pro-resilience factors.[154] [155]

106. Positive relationships with peers and siblings, and self-esteem, are further protective factors that may mitigate the impact of family violence on a child's development but require further research.[155] For example, recent work showed positive sibling relationships are difficult if all family members are being maltreated or witnessing violence. [156] Self-esteem is hard to build in the absence of

caring relationships that communicate that a child is loveable and in the face of the shame and misplaced responsibility that children take on for the perpetrator's violence [157] (*There's something wrong with me that I am being treated like this).*

107. Research attention is increasingly being paid to the child's wider environment as a key to resilience, shifting away from focusing only on how to "fix" (or, worse still, punish or incarcerate) a child who is damaged, and more towards how to fix the interactions around them, which have differential impacts on them depending on circumstances. [158] Differential impact theory is an ecological approach, where the whole ecology in which the child is surviving is relevant to better counter risk factors with social factors more likely to promote children's positive development:

> Resilience, understood ecologically, is the capacity of individuals to navigate their way to the resources they need to succeed and their ability to successfully negotiate for resources to be provided in ways that are meaningful to them. (p. 4)[159]

108. The resources towards which children (or anyone affected by family violence) need to navigate (such as attachment, safety, emotional skills, recovery from harm, social and educational opportunity), may be provided by anyone from parents, family/whānau, neighbourhood and community to those in education, health, welfare and justice services, but ideally in a coordinated, networked way.[159]

109. This theory argues that environments cause children to change for the worse, so we need to change environments for the better; however, interventions need to match the level of exposure to harm (thus, removing a child from the family home may be necessary in high-risk situations and very harmful in low-risk situations); and the more complex the challenges in the child's life, the more complex and integrated the interventions need to be (for example, coordinated responses from the school, caregivers, cultural, mental-health and child-welfare services). Thus, rather than expecting a child or family to adapt to whatever intervention happens to be available, a coordinated, coherent response to all the issues they face is needed, and working *with* them so that services really understand what will make a difference.[159]

110. Although such a coordinated, ecological approach seems self-evident, the simplistic, default position of, "*That child should just learn to do what they're told*" or "*Oranga Tamariki should just take charge*" can be commonly heard. Such comments show how easy it is to blame victims and oversimplify behavioural change in children; and to expect child-welfare services, who are funded to assist only those most at risk, to flawlessly save everyone and predict everything, while we keep ignoring our friend's controlling behaviour towards their partner and children... As a community, we need to ask what role we all play in the lives of children, families, wider relationships and access to help when needed, to ensure we can all build resilience, positive relationships, recover well from bad experiences and flourish.

Prevention of family violence

Early childhood and adolescent factors are consistent predictors in the development of domestic violence perpetration and victimisation … prevention and early intervention targeting these factors are likely to prove the most effective.[160]

111. As already mentioned, it is important to note that by no means do all those who experience violence and abuse early in life go on to offend in the criminal-justice system—but the vast majority of those who ***do*** offend have experienced violence and abuse early in life, especially those who offend repeatedly and from early childhood and adolescence right through adulthood (so-called "life-course-persistent offenders" [161]). Similarly, those who experience family violence and maltreatment in childhood are at risk of experiencing a range of negative adult outcomes that make prevention and early intervention vital.

112. Table 1 summarises strategies drawn from the international CDC report[17] and the health sector.[162] [163] Item 8 has been added (*Take action, measure the action etc*) - it may seem self-evident but is discussed further in the final section on *Implementation science* – the difficulty we seem to have as a society with doing what's needed to act on and change family violence rates forever. These areas must be culturally interpreted – they are broad categories of action that need to be led by appropriate communities.

TABLE 1. PREVENTION OF FAMILY VIOLENCE

Strategy	*Approach*
1. Understand the effects of adverse childhood experiences	Broaden public and professional understanding of the effects of adverse childhood experiences to drive community-wide commitment to early prevention and intervention and ending family violence.
2. Change social norms to support positive parenting, healthy relationships and a non-violent NZ	Social and cultural norms about relationships and families, alcohol and violence, and legal-system responses all affect how individuals enact or respond to family violence. Understand the media focus on victim-blaming and individual service failure vs. awareness-raising and change.
3. Strengthen economic supports for families	Family violence occurs at all income levels but having financial resources can enhance options for leaving a violent relationship or keeping children safe. Financial demands on parenting are high, and economic disadvantage increases household stress and reduces access to safe housing, healthcare and help.
4. Build workforce capacity and capability	Trauma-informed care has at its centre the voices of children and young people affected by violence and maltreatment, and the voices of partners and parents experiencing violence. Staff in all sectors need to be adequately resourced to understand and respond to family violence and avoid re-traumatisation.
5. Enhance parenting support and skills to promote healthy child development	If violence has primarily been modelled in parenting, it is important to be able to learn other strategies. Targeted, evidence-informed, home-based and sustained programmes can help high-risk families. Feeling part of the neighbourhood, community and culture helps lower child abuse risk for all.
6. Provide quality early childhood care and education	Early home-based support from pregnancy; high-quality early childhood care and education; school engagement and intervention around early challenging behaviour can all reduce risk and promote resilience.
7. Intervene to lessen harm and prevent future risk with a trauma-informed approach	Coherent, collaborative service delivery is needed, drawing on child-focused interventions, positive youth development, advocacy-based help, family support, intervention for addictions and trauma, work with perpetrators, risk prediction and technology tools as appropriate.
8. Implementation science: Take action; measure it; do more of what works; allow what is learned to inform next steps	A well-planned implementation strategy is vital, to balance evidence-informed programmes and real-world contexts, evaluate appropriately and maintain programme fidelity when scaling up. Support for emerging and promising practice, and funding for research and evaluation relevant to diverse, local, social and cultural contexts, are needed.

113. These strategies aim to prevent child abuse and neglect from occurring in the first place as well as reducing the impact for those who have already been affected. The focus of these strategies ranges from wider social understanding and changing social norms, enhancing economic and workforce strengths, through supporting parents, early childhood care and education, to individual and family/whānau intervention. Research related to each area is briefly mentioned.

Understand the effects of adverse childhood experiences

114. Part of a more systemic, trauma-informed approach includes wider understanding of the impact of adverse childhood experiences (ACEs). This can drive a whole-of-society commitment to early prevention and intervention, and ending family violence. ACEs include harm that affects children directly (such as all forms of abuse and neglect) and indirectly (such as witnessing intimate partner violence or living with people who are abusing alcohol and drugs). Circumstances of food insecurity, homelessness, caregivers who are acutely unwell (in a way that affects their capacity to parent) or put in prison are also seen as adverse childhood experiences.[164, 165]

115. Such experiences are seen as exposing children to chronic stress that has physiological effects – that is, research shows the child's nervous system, immune system and endocrine system can all be affected, with lifelong physical and mental health effects, especially when children face multiple ACEs.[165, 166]

116. For example, in New Zealand's Dunedin longitudinal study, children with documented histories of maltreatment, socioeconomic disadvantage or social isolation had negative health effects, including risk markers for heart disease by age 32. [167] Measures of depression, inflammation and metabolic risk factors (associated with diabetes and cardiovascular disease, for example) were higher in those adults who had had more adverse childhood experiences, than in those who had had fewer.

117. Such findings are consistent with the idea that ACEs disrupt normal responses to stress. Further research tracking the effects of childhood adversity on the health of Dunedin study participants at age 45 will include neuroimaging to track effects of childhood maltreatment on brain structure and associated outcomes in mid-life.[168]

118. As researchers have noted, as a society, we directly tackle risk factors for physical illness, such as smoking, sunburn or asbestos exposure, but often fail to apply a similar preventive approach to the effects of family violence (pp. 316-8):[162]

> *With chronic physical diseases, successful prevention efforts have focused on reducing the big risk factors. If this approach is applied to mental disorders, the big risk factors are adverse childhood experiences, which have major effects on most classes of mental disorder across the lifespan … [including] problematic alcohol and drug use, and interpersonal and self-directed violence.*

119. A recent meta-analysis found that having multiple adverse childhood experiences was most strongly associated with problematic drug use, self-directed violence (such as attempting suicide) and interpersonal violence.[165] A longitudinal sample of UK young offenders (now aged 56) showed that those who had experienced more ACEs by the age of 10 had a higher likelihood of offending by late middle-age than those who had experienced fewer.[169] Also, a study of more than 22,000 young offenders in Florida, US showed that for each ACE they had experienced (such as physical abuse), the risk of being a serious, violent and chronic juvenile offender was increased by more than 35%, even when other known risk factors for offending were controlled for (such as gender, socioeconomic status, peer influence etc).[170] The childhood experience of having a family member in prison, in particular, was associated with an increased risk of serious offending by 119%.[170] These strong associations go some way to explain the intergenerational cycles of violence.

120. Maternal ACEs have been associated with increased pre- and post-natal depressive symptoms,[171] which, in turn, could have an impact on the ability to parent, especially without support, and intergenerational effects.[172]

121. Adversity does not need to be extreme to impact on future psychosocial functioning[171] and, conversely, some apparently "resilient" children may be enduring sub-clinical levels of maladjustment. [173] There can also be patterns of adverse experiences that are associated with each other – for example, household violence has been found to always co-occur with emotional abuse (that is, where there is violence, there is emotional abuse), but not necessarily the other way around (there can be damaging emotional abuse without overt violence).[171]

122. Definitions of ACEs and ways to measure their severity and impact continue to develop. An ACEs questionnaire of 10 major types of adversity (where a score of 4 or more is of concern) is a tool for indicating further assessment, rather than a definitive measure or diagnosis.[174] Victimisation by peers, peer isolation/rejection, and community violence exposure (e.g. living in a neighbourhood that is dangerous or where you have seen someone being assaulted) have more recently been suggested as ACEs.[175] There is also consideration of "structural violence" imposed by entire systems (whether social, political or economic) that result in unequal power and unequal life chances, racial and ethnic disparities, and marginalised children who do not get full access to resources.[176]

123. In addition, questionnaires around resilience and factors protecting against the effects of adversity have been developed. [177] These remind us of the ability of children and families to recover and the role of the community in helping them to do so (such as in resilience items like, "When I was little, other people helped my mother and father take care of me and they seemed to love me" or "When I was a child, neighbours or my friends' parents seemed to like me"[177]).

Change social norms to support positive parenting and non-violent relationships

124. Changing social norms about how we treat each other is hard but possible. We no longer allow children to be beaten by adults in schools or government institutions. We know that cigarette smoking around children is harmful. Legislation is sometimes a necessary part of shifting social norms, along with evidence – think, seat-belts in cars and sun-hats in school playgrounds. In relation to violence, we need to change social norms around alcohol consumption,[178] [179] which is associated with an increased risk of aggressive behaviour, interpersonal violence, intimate partner violence[180] and offending.[181] [182]

125. Media coverage is important. There is a tradition of media focus on child-welfare agency failures, as opposed to noting the community responsibility we all have to keep all children and families safe; this needs to change. Research on five years of New Zealand media coverage of child-welfare agency Child Youth and Family (the predecessor of Oranga Tamariki) showed an emphasis on the individual cases of harm that were poorly managed by the agency (regardless of whether there was also poor management by the perpetrators of the abuse or murder, the caregivers, friends and family, neighbours, communities, health professionals…). There was almost no mention in the media coverage of the 100,000 other cases per year where things had gone more smoothly or that were less impossible to manage.[183]

126. As discussed in the first report in this series, painful examples of criminal victimisation feature in media coverage and public discourse, and have driven much of that public discourse. Discussions of prevention or successful prevention programmes rarely feature.[184]

127. Similarly, in media coverage there is a portrayal of child abuse as a "Māori issue".[185] The long history of healthy Māori parenting, pre-colonisation, is never mentioned, whereas an individual case of a Māori child being harmed may be luridly described and implied to be the "norm".

128. Help is crucial to "break the cycle" for both perpetrators and survivors and can be from many domains. For one person, a cultural group and regaining an important cultural identity (including culturally acceptable ways to respectfully treat others) may help them stand strong against violence. For another, a religious or spiritual group and spiritual guidance might help them to change. For still others, psychological therapy, including understanding how their past abuse in childhood has taught them unhelpful ways to behave in the present, and learning new skills, may be the way. It is beyond the scope of this report to cover all the ways that adults can work towards no longer being perpetrators of violence or recover from its effects. What we must focus on is how to prevent our staggering rates of family violence persisting into the future and affecting the brains and behaviour of babies being conceived today and how – as a society – we must make that happen.

129. Globally, the UN Sustainable Development Goals emphasise child development and parental nurture need to be political priorities (p. 103):[186]

> *The scale-up of early child development programmes rests on political prioritisation of efforts to address deep social problems such as poverty, inequality, and social exclusion through interventions starting early in the life course.*

130. Such priorities can begin with all of us. We can help in our neighbourhoods - research with New Zealand women who lived in communities where they felt supported showed they were less likely to report ever experiencing intimate partner violence. [187] For example, they felt their neighbours would help if there was illness or injury, and also that they could count on wider family support. Yet, such "informal" social support is also not enough alone – many of those who had experienced intimate partner violence did have neighbourhood and family support but needed more than this "informal" support to be able to safely leave a violent relationship. [187] Again, partnership is key, among all of us as neighbours, family/whānau and friends, who can also reach out to timely and available professional help from police and legal and social services when necessary.

131. The *It's not OK* campaign was launched in 2007 as a public health campaign – that is, it was based on recognising that the fundamental shifts that are needed to prevent family violence take time and resources; that misperceptions about family violence can be targeted in national media campaigns but need to be leveraged by community-level social intervention; and that research and evaluation should inform the media and community campaigns.[188] A 2015 evaluation found that the campaign had:

- increased awareness and message infiltration
- increased willingness to discuss family violence
- inspired people to intervene
- led to young people changing their behaviour
- led to changes to organisational culture
- developed a sense of community ownership
- led to an increase in family violence reports to Police and lower thresholds for people reporting. (p.1)

132. Key components of the *It's not OK* campaign were reported to be the combination of the national media campaign resources with local coordinators who were able to focus on family violence *prevention* (that is, not having to also do case management) and campaign champions (community leaders and champions leading community responses, often with personal stories of ending violence). However, the evaluation reported that the barriers to continued success were the lack of resources of all kinds to cater for increased family-violence notifications, including comprehensive support for women, improved access to local safe houses, and timely access to men's programmes and services related to alcohol and other drugs. Campaigns can raise awareness and notifications of family violence – and

therefore also raise demand for services of all kinds – yet community and social services are not scaled up to meet that demand, as this community provider commented (p. vii):[188]

Family violence reports have increased by fifty per cent but the amount of social service funding has remained stagnant.

133. A 10-year plan getting underway in the Australian state of Victoria highlights the range of areas to address in putting an end to family violence, which is the stated aim of their campaign. [189] Funding has been specifically allocated to prevention (including a gender-equality strategy and work in schools); "support and safety hubs" (offering women, children and young people a safe place to get coordinated justice, health and social-support services); legal reforms (including perpetrator accountability and specialist family-violence courts); workforce development (including police family-violence specialists and building family-violence skills across justice and social-service staff); safe and stable housing (redeveloping and building more refuges); and better information-sharing across police, courts, justice and social services to improve safety and manage perpetrator risk.

134. Legal reforms are influenced by – and influence – social norms. New Zealand is among the 51 countries that have legally prohibited all physical (or "corporal") punishment of children, [190] as international endorsement of the rights of children to protection and dignity grows, and any distinction between physical punishment and physical abuse is contested. Decades of research show how ineffective smacking and physical punishment are at improving children's behaviour, more often causing it to worsen over time, and to risk a range of harmful behavioural, cognitive, and physical- and mental-health effects.[190, 191] However, social norms to support positive parenting need to continue to be strengthened (p. 10):[190]

The fact that parents continue to use physical punishment, despite the accumulation of scientific evidence that it is both ineffective and harmful to children, indicates a clear need for strategies to prevent it.

135. A review of various New Zealand surveys from 1981 to 2013, for example, showed that endorsement of physical punishment has dropped from 89% to 40% for items like, "There are certain circumstances when it is alright for a parent to use physical punishment with a child."[192] Further shifts in social norms are needed, in addition to the legal ban, [193] to reduce further this 40%, including how to parent non-violently while teaching children what we want them to learn. [194] Researchers note that public education, such as having information displayed in doctors' waiting rooms or a brief online summary explaining the harm of physical punishment and showing alternative behaviour, can be worthwhile.[190, 195] There are also efforts to address interpretations of Christian *Bible* verses that are seen as endorsing physical punishment (e.g., Proverbs 13:24 Those who spare the rod hate their children, but those who love them are diligent to discipline them).[196]

136. While our law has moved against physical abuse, there are legal anomalies in relation to the so-called "failure to protect" provision, a complex issue because those who are aware of abuse (e.g., of a child) are often also experiencing abuse (e.g., from a partner) and reporting it to authorities could put them at risk of being charged with "failure to protect" the child: [197]

The introduction of a "failure to protect" provision into the Crimes Act 1961 in 2012 has the potential to further hold victims responsible for the perpetrator's violence. This provision extends a duty to a parent or anyone living in the same household as a child at risk of harm to take "reasonable steps" to protect them. A person considered to have failed to do so is liable for up to 10 years' imprisonment.

This adds the risk of criminal liability to women's perceived culpability for men's violence towards children. It also contradicts Section 3 of the Domestic Violence Act 1995, which states that "the person who suffers the abuse is not regarded as having caused or allowed the child to see or hear that abuse, or as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse." (pp. 26-7)

137. Social norms around masculinity in New Zealand are called into question by those in the family-violence field. For example, a "collective masculine identity" is seen as having been built up around traditional European and other cultural beliefs that "men should be in charge" (p. 14) and that a man's dominance at home is the "natural order of things" (p. 46).[198] Finding positive, non-violent male role-models for boys is therefore part of early intervention:[199]

We should be looking for potential positive male role models, heroes, not in the public arena but among men in our boys' lives – their grandfathers, uncles, older brothers, teachers and coaches and, most of all, their fathers.

138. Religious and spiritual beliefs and practices can be a source of support and recovery from trauma,[200] but social norms derived from religious beliefs can also be of concern. For example, work from within seven Pacific communities in New Zealand (Cook Islands Māori, Fijian, Niuean, Sāmoan, Tokelau, Tongan and Tuvaluan) describe mis-interpretations of biblical texts and cultural beliefs that are seen to endorse the rights of men to "discipline" women and children and to view women as "subordinate" to men.[201] English 19th-century missionaries to NZ and the Pacific preached Victorian patriarchal values, and provided literal interpretations of biblical verses to support them; there are calls for Pacific churches to consider family violence in relation to such interpretations.[202] Given the influence of the church for many Pacific people, culturally appropriate approaches to family violence that engage cultural and Christian values, noted in ethnic-specific reports,[201] could be explored; some are underway.[203] Principles in the Qur'an are also variously interpreted as giving men and women equal respect, or giving men the right to "discipline" and punish women.[204]

139. All intimate partner violence needs to be prevented, and circumstances surrounding such violence better understood. Early intervention is again important; the International Dating Violence Study (across 32 countries) of 13,659 university students showed both men and women who had experienced childhood sexual abuse were more at risk of enacting physical violence in their adult relationships than those without such a history.[205] In a review of 50 studies, both male and female perpetrators of psychological violence attributed their behaviour to issues like "anger, control, self-defence, retaliation and/or a desire to get attention" (p. 240)[206]; for physical violence that included both partners, risk factors were having alcohol problems and histories of childhood violence.[207] Other research has explored links between relationship dissatisfaction, heavy drinking, and lack of emotional regulation skills in mutual partner violence.[208] Longitudinal research in Christchurch showed that childhood abuse, family adversity, conduct problems and alcohol abuse were significant predictors of intimate partner violence for both men and women by age 25.[209] All such aspects may help guide targets for prevention and intervention.

140. Gender and cultural differences continue to need to be explored; for example, where women's physical violence is used as self-defence in the context of a man's violence or where men report less emotional impact, less severe injuries, or to less often feel that their sense of safety or wellbeing is affected in the context of a woman partner's violence.[210] More culturally appropriate definitions, measures and approaches to violence will also improve prevention and intervention.[211] [212] [213]

Strengthen economic supports for families

141. Poverty has been consistently associated with child maltreatment and family violence for some people, but by no means for all, and people with high incomes also steadily appear in child-maltreatment and family-violence statistics.[214] For example, as noted, one in four (26%) of New Zealand women who live in a home with a household income of more than $100,000 per year have experienced physical and/or sexual violence from an intimate partner.[215] Understanding what protects some people and not others, and how income can combine with other risk factors to increase violence, remain research challenges.[10] [11]

142. Research with New Zealand women showed that, where both the woman and her partner were employed and had increased family income, there was a reduced likelihood of currently experiencing intimate partner violence.[187] Having more financial resources to leave a relationship, and potentially more social supports (through being employed outside the home), may contribute to the capacity to leave a dangerous relationship. However, there is also concern that family violence in privileged households stays under-reported and the reputation of the perpetrator remains protected while women remain isolated and quiet via the discreet supports of a private therapist or getting away to a hotel (instead of a women's refuge or police involvement).[214]

143. Reducing the economic burden on families is likely to result in improved parental ability to meet children's needs, reduce stress, and reduce the risk of child abuse and neglect.[17] Poverty can create stresses and constraints that thwart parents' efforts to provide the kinds of nurturing care they desire for their children.[74]

144. There are direct links between income and parenting tasks – adequate income is needed to provide adequate food, good housing, clothing, transport and the ever-increasing costs associated with education and healthcare.[216] Indirect pathways may include lack of parenting time (quality and quantity) due to low-wage work commitments; psychological effects of stress, anxiety and depression related to material hardship, including turning to substance abuse; psychosocial impacts of unemployment or job insecurity; or changing family structures to deal with financial constraints (such as overcrowding in homes or lacking resources to move into another home away from abusive or conflictual relationships).[216]

145. An evaluation of material supports (e.g., good housing, food, clothes, financial aid to pay power bills) to families engaged with child-welfare services found these supports predicted a range of positive outcomes, including higher engagement, attainment of goals, and lower short-term parental-violence recidivism. Material supports may therefore temporarily reduce family stress, facilitate treatment engagement, and lead to increased short-term child safety.[217]

146. Policies that raise the living standards of families in general tend to yield the largest positive public-health outcomes across child development, health and educational outcomes.[218] Increases in the minimum wage have been linked with decreases in child-maltreatment reports, and particularly so for young and school-aged children. Specifically, in US research, a $1 increase in the minimum wage was associated with a decline in reports of neglect by nearly 10%.[216] In Canada, a "living wage" trial was associated with reduced risk factors for child abuse and neglect such as low education levels and high rates of psychiatric problems.[219]

147. Poverty and economic uncertainty during the global financial crisis (2007-10) were associated with increased rates of harsh parenting, which is a risk factor for child maltreatment.[220] A recent Australian study estimated that nearly 30% of child-maltreatment cases were collectively explained by economic factors, indicating that reductions in economic disadvantage are likely to substantially reduce child-maltreatment rates.[221] Because un-employment has been shown to be the most modifiable economic risk factor for child maltreatment, policies to reduce unemployment may concurrently reduce child maltreatment.[221]

148. In addition, "family-friendly" work policies, such as adequate leave, sick leave, holiday pay, and flexible and consistent schedules (especially for part-time and shift work), enhance parent and child outcomes.[17] Unpredictable and irregular work schedules have been associated with increased parental conflict and stress and increased rates of cognitive deficits and behavioural difficulties in children. [222] Introducing adequate paid family leave in California was associated with a drop in hospitalisations for abusive head trauma in children aged 0 to 2 years old, in contrast to seven other US states that had no such policy.[223]

149. Increased rates of paid maternity leave in Australia were associated with increased rates of breastfeeding, which is, in turn, associated with reduced risk of child abuse and neglect. [224] Another "family-friendly" work policy is the world-first "Domestic Violence-Victims' Protection Bill", which provides leave from work to deal with issues related to family violence. It takes effect from 1 April 2019 in New Zealand, and its consequences will be important to track.

150. Low-income groups can be disproportionately affected by adverse childhood experiences (ACEs, as discussed), [225] which, by definition, include food insecurity and homelessness; these are directly affected by financial circumstances. Also, ACEs can be associated with diminished later life opportunity – traumatised children may not do so well at school, hampering further education and high-income employment opportunities, or increasing the risk of criminal-justice involvement. As such, strategies designed to decrease economic disadvantage are likely not only to benefit those who are currently impacted by poverty but also to reduce intergenerational disadvantage.[225]

151. There is emerging evidence of a probable causal association between maltreatment as a child and poorer economic outcomes as an adult, even after the socioeconomic status of the child's family of origin is taken into account. [226] The economic disadvantage relates to income, employment, job-skill levels and accumulation of assets, and is derived from research where there has been substantiated child maltreatment, whether child sexual abuse, physical abuse, neglect and/or family violence. For example, a US study showed that by middle age, there was a 14% gap in the probability of being employed between those with a childhood history of abuse/neglect and matched controls without.[227] A 2018 research review found associations between at least one maltreatment type and at least one economic measure, but more evidence is needed, with research on the economic outcomes of childhood neglect particularly lacking.[226] The associations point to the need to prevent child maltreatment and therefore also prevent the socioeconomic disadvantage that can compound the challenges of parenting the next generation. Again, investment in support for children from conception is more cost-effective than later remediation (p. 397):[228]

> *Recent evidence shows that investing in the capabilities of the children today is the most cost-effective policy to promote the capabilities of the adults tomorrow. This argument makes sense both on equity and efficiency grounds. Despite the logic and the evidence, most policies still overlook the efficacy of early interventions, leading to an underinvestment in the skills of very disadvantaged children.*

Build workforce capacity and capability

152. A crucial element of ending family violence and child maltreatment is a well-trained workforce, well-supervised to conduct evidence-based, culturally appropriate interventions in homes, schools, NGOs, statutory agencies and the community. "Trauma-informed care" has, at its centre, the voices of children and young people affected by violence and maltreatment and the partners and parents experiencing violence. Respect, engagement, enduring relationships, a sense of safety, and access to the resources and structures needed to make change are all vital.

153. There is a dearth of programmes (both community and tertiary programmes) that

teach people, in both the NGO and statutory sectors, the principles of trauma-informed care. From lawyers to police, from school-teachers to babysitters, to all those working in the health and social sectors, *effective* and *practical* skills to work with children, young people, adults and families/whānau who have or are experiencing violence and abuse, are needed. There is a need for resources aimed at teaching trauma-informed skills to be widely available, especially focusing on engaging well with so-called "hard-to-reach" survivors and families. This is not about everyone being frontline mental-health experts but that our awareness and skills are built so that where there has been trauma, there is more understanding of the likely needs of the child/family, and how to access appropriate help. The Māori workforce needs to be built, and non-Māori workers will require specific training in te ao Māori content and cultural competency. The Pacific workforce and non-Pacific cultural competency also need to be built. The workforce also needs to be responsive to the increasingly diverse make-up of New Zealand, their ethnicities, social, sexual, and gender identities and disability status.

154. A recent outline of a trauma-informed approach[229] draws on substance-abuse and mental-health work but can be relevant to those working in all aspects of family violence, including child-welfare and social services, the legal profession, police, and others working in justice, education and health. [230] Briefly, it is an approach that includes:

- **The three Es** – trauma involves an **event/events**; the person's **experience** of it defines whether it is trauma (we experience and cope with events differently); and the trauma has lasting adverse **effects**.
- **The four Rs** – People at all levels of an organisation need to **realise** the widespread impact of trauma and potential paths to recovery; **recognise** the signs and symptoms of trauma; **respond** by integrating knowledge of trauma into policies and procedures; and seek to actively **resist re-traumatisation.**
- **Six principles** guide practice: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment voice and choice; and recognition of cultural, historical and gender issues.
- **Ten implementation domains**: an awareness of trauma needs to inform, across sectors, governance & leadership; policy; physical environment; engagement and involvement; cross-sector collaboration; screening, assessment and treatment services; training and workforce development; progress monitoring and quality assurance, financing; and evaluation.[229]

155. Trauma-informed care cannot be seen as the latest "one-size-fits-all" Western approach – the sixth principle calling for "recognition of cultural, historical and gender issues" must be applied. Engagement with Māori and Pacific theories, understanding and models to support change for children, parents and whānau with intergenerational trauma histories, as well as organisational and political commitment to such approaches, are all called for.[231] Services need to provide help in a culturally appropriate, mana-enhancing way, and understand the effects of complex, historical trauma.[54]

156. One of the barriers to engaging with ideas of trauma is quite simply a sense of horror at what can occur in family violence and child maltreatment. "To stand as witness to the extent and horror of people's accounts of pain and suffering is to encounter and experience fear, despair, loss and rage" (p. 183).[232] Maybe that is why we sometimes do not want to know what might be happening to our workmate or the children down the road. Those working in the child-welfare field, police, lawyers, health professionals and the education workforce need to have support and supervision to manage the sense of horror that they may feel – and to maintain hope that things can change.

157. Research suggests that children with histories of maltreatment are less likely to get evidence-based treatment than those children without, in part due to family and

social factors, and service structures.[233] It can be most effective for a sustained keyworker relationship to be established to help the child and family find their way through appropriate input over time. Staff can help work through barriers such as a lack of knowledge about appropriate services, including how to access them, and fear of stigmatisation, as well as system constraints such as changes in living circumstances and lack of financial resources (e.g., for transport to get to services). [234] A sustained, co-ordinated approach to achieve recovery goals is needed, instead of a focus on short-term outputs, service by service, each with specific boundaries (so that a person's change of address means a change of service and team).

158. A New Zealand community mental-health centre audit of files, similar to one done a decade earlier, showed that mental-health staff were getting better at asking about the abuse histories of people referred for mental-health care, i.e., becoming more trauma-informed.[235] However, neglect was less often raised, women clients were more often asked about abuse histories than were men (yet men are particularly reluctant to disclose childhood abuse spontaneously and to get the help they need, so being asked is important) and female staff were more likely to inquire than were male staff. Some training is helping overcome barriers to assessment, including fears that asking about trauma will be better at another time because it will be seen as suggestive, irrelevant, or get in the way of more immediate concerns like suicidality. Staff can also feel that they would not know what to do or say if a disclosure was made, so ongoing training is needed (p. 102):

> *Training must include not only when and how to ask, but how to respond to disclosures. Taking a psycho-social history, including abuse/neglect and other adversities, is only the first step towards creating a shared formulation of the causes of the current problems and providing a comprehensive support/ treatment package which addresses, if necessary, historic and ongoing adversities.*[235]

159. A family-violence workforce capability framework, launched in 2017, outlines the competencies, knowledge, skills and organisational support needed by the workforce to recognise and respond to family violence, sexual violence and violence within whānau.[236] The framework is being initially implemented by several early adopter organisations as well as tested across sites in the Waikato and Christchurch.

Enhance parenting support and skills to promote healthy child development

160. There are various types of therapeutic interventions for parents who have experienced family violence and trauma that are beyond the scope of this paper to outline in detail, beyond noting that access to all forms of culturally appropriate, affordable psychological therapy is limited in New Zealand. Cognitive trauma therapy has been shown to reduce post-traumatic stress and depressive and anxiety symptoms and increase self-esteem in women who have experienced family violence[237] but needs to be more widely available, as do all forms of relationship therapy, family therapy and interventions for perpetrators and survivors of family violence.

161. Parenting programmes are somewhat more available and can help break the intergenerational cycle of violence – if violence has primarily been modelled in one's own experience of being parented, it is important to learn other strategies as that child later becomes a parent – including, especially, how to build good attachment. A recent review of successful interventions for parents of infants and toddlers (aged 0-5 years) found that these interventions predominantly focused on modifying parenting practices, the parent-child relationship/attachment, and reducing child abuse and neglect.[238] For example, praise and reinforcement is key to good behaviour – parents are taught to use a 6:1 ratio of praise to reprimands, including labelled praise, where the parent names the behaviour they like when it occurs.

162. There is a wide range of evidence-based parent-training programmes, e.g., Triple P[239] and Incredible Years [240], which have been

shown to improve the lives of children with child-welfare concerns, including their New Zealand adaptations.[241,242] Research shows that even the minimal employment of such programmes in the child-welfare sector represents a crucial and frequently missed opportunity to positively affect the lives of children and their families/whānau. [243] Provision of programmes that ensure engagement and access for parents (transport, childcare, sessions available outside of work) – that is, that are client-focused – needs to grow.

163. Parenting programmes successfully reduce reported child maltreatment (both substantiated by authorities and parents' self-reports) and also the potential for child maltreatment, according to a recent meta-analysis. [244] Programmes included parent education, some with home visiting, including targeting for higher-risk parents. Programmes that started in the prenatal period were helpful in preventing maltreatment; and parents with a history of child abuse could also benefit from delivery of evidence-based interventions. The authors confirm that "parenting programmes offer an effective, strengths-based approach to reinforce positive parenting and prevent child maltreatment" (p. 100).[244]

164. Again, early intervention is best – we need to better prepare people for becoming parents. For example, a randomised controlled trial (RCT) study found that a parent-training intervention with couples about to become parents was effective in improving a range of parenting outcomes, including parenting skills, parental mental health, co-parenting, and child adjustment, and had particularly large effects on reducing family violence.[245]

165. A 2018 review of evidence from 14 parenting programmes that were effective in preventing maltreatment of school-aged children listed nine common components:[246]

    1. **Target participants:** Given limited resources, services should target parents who have already been unable to parent well, or are at high risk of being unable to.
    2. **Programme content:** Models like cognitive-behavioural or social-learning theory were common, and content covered child-rearing practices (e.g., how to reinforce good behaviour rather than be punitive), family communication and interactions (how and when to communicate effectively), and how to manage feelings better (so-called "emotion regulation").
    3. **Programme objectives** emphasised improving parenting skills, followed by improving the parent-child relationship and then changing children's behaviour (whereas we often think parenting is first about tackling kids' bad behaviour…).
    4. **Interaction methods** varied, including group and/or one-on-one sessions, but having a programme manual was important to maintain treatment fidelity, and there was a focus on *practical* parent education, including modelling different ways to respond to children.
    5. **Practitioners were trained,** both in relevant disciplines and in the specific programme, with regular supervision of practice often a requirement.
    6. **The setting of the programme** was often in the home, or there was a mix of some programme delivery provided at home and some in community locations.
    7. **Time required** was at least 1-2 hours per week, for at least 3 to 6 months, with some programmes requiring up to 8-10 hours per week. The main point was that these are not seen as "quick fix" programmes but sound investments in the future.
    8. **Parents' responsibilities:** The parents are seen as agents of change, who need to be "empowered" to parent more effectively. They are expected to do homework tasks (such as spending 10 minutes per day playing with the child) and given coaching on how they manage such tasks.
    9. **Evaluation of programme fidelity:** Ensuring what is provided actually follows the evidence-based guidelines is an important part of good programmes.

166. Parenting interventions specifically targeted at parents exposed to intimate partner violence are highly heterogeneous and more research is required to determine their efficacy on improving child and family outcomes.[247] It is obviously ineffective merely to mandate a parenting programme when a parent is surviving or perpetrating ongoing violence. New Zealand researchers point out that the roles of "father" and "partner" cannot be separated in relation to violence (p.1):[248]

Parenting programmes for fathers who have used violence need to emphasise the need to end violence against their children's mothers (they cannot be "a lousy partner but a good dad").

167. Recent research points to a role for parenting programmes to help prevent childhood sexual abuse. Traditionally, child sexual-abuse prevention programmes have focused on teaching children how to "identify, avoid, and disclose" sexual abuse (p. 96).[249] A recent Australian research review, however, advocates a broader approach, based on evidence of how child sexual abuse is perpetrated. Research with offenders showed they target children who are less well-supervised by parents/caregivers or in circumstances where the caregiver-child relationship is less protective (and therefore the child is unlikely to express their worries to the parent about another adult's behaviour). The researchers recommend that parenting programmes could include information about how perpetrators groom and isolate children, treating them as "special", taking advantage of parental problems with violence, substance abuse, challenges of dealing with physical and psychiatric illness etc, and of potentially risky situations (such as non-family involvement in bedtime or intimate tasks).

168. They also highlight that it is important for parents to understand that possible perpetrators include partners, step- and foster siblings, older children/adolescents (rather than the far less common "stranger danger"), and that all families need healthy boundaries and privacy protocols. Prevention is therefore afforded directly by good parental supervision and family boundaries and indirectly by promoting a child's self-esteem, wellbeing and competence through close, supportive relationships.[249]

169. The manner in which parents perceive and interact with their environment (e.g., whether they feel people in their neighbourhood get along with each other or share the same values), along with their participation in their community, impacts on the way they parent their children. Community participation (defined as involvement in anything from a local child-focused group through to neighbourhood, religious, cultural or political groups, activities or events) has been associated with lower risk of child abuse.[250] It makes sense that ongoing community engagement and social networks, in contrast to social isolation, helps support prevention of intimate partner violence and child maltreatment by providing those at risk with more support options.

Provide quality early childhood care and education

170. Home visitation (where there is targeted help at home from birth) has been found to be a key programme, with a significant evidence base for reducing child abuse and its effects.[251] [252] Greater programme efficacy has been found with visits starting in pregnancy and continuing for up to 2 years (or even up to 5 years); weekly visits in the immediate post-partum period; longer follow-up post-intervention; and focused intervention. Home visitation has been found to impact on mother-infant interaction, maternal depression, repeat pregnancy, maternal employment, as well as cognitive development and externalising behaviours of children.[253] [254] Recent research on the DNA methylation across the genome of child participants, now aged 27 years, show the persisting influence of the early social environment and intervention in the first two years of life.[255]

171. There are a number of early home-visiting programmes in New Zealand. One example is

Start Well Māngere, which is working intensively with mothers under the age of 20, their babies and wider whānau.[256] It is using a flexible, combined health and social model of care, partnering with and drawing on existing universal health and targeted social services. It is staffed by nurse and social-work specialists. It is taking a strengths-based approach, with a focus on whānau partnership from pregnancy until the child is 5 years old, flexibly providing more or less support over time as needed. By supporting young mothers and reducing the levels of stress experienced by whānau, in areas ranging from housing to health literacy, and from substance use to family violence, the aim is to improve carers' cognitive and emotional "bandwidth" for responsive parenting and minimise impacts of multiple stressors on early brain development and later outcomes (including youth-justice involvement), which can be evaluated.

172. In infancy, high-quality early childhood care and education is associated with improved psychosocial outcomes and increased likelihood of experiencing safe and nurturing environments.[17] Evidence indicates that high-quality childhood and education programmes are associated with range of positive outcomes for both children and their families, including reduced rates of child maltreatment[257] [258] and educational benefits lasting to midlife.[259] Increased access to such care is associated with fewer risk factors for child maltreatment, such as reduced parental stress[260] and maternal depression.[261]

173. Research shows that children from at-risk circumstances who were engaged in quality early-childhood care have better cognitive outcomes, social skills, family support outcomes and well-being.[262] [263] Furthermore, cost-benefit analyses have shown that such programmes are cost-effective, with beneficial effects from high-quality early intervention tracked through to adulthood.[264] [265] In contrast, substandard childcare (particularly where low income is a barrier to accessing a high-quality provider) is a risk factor for child abuse. [266] Establishing consistently high-quality ECE, especially where there are vulnerable or at-risk communities and families, is important and there is a 10-year strategic plan currently under NZ consultation, including the need for appropriate developmental assessments of risk or harm.[267]

174. For some children experiencing family violence, entry to primary school may be the first time their trauma and related problematic behaviours become evident; by age 10, children may be truanting, suspended, and engaged in "nuisance" offending, with low school achievement typical.[268] Fetal alcohol spectrum disorders,[269] developmental disorders, ADHD and speech and language difficulties (and resulting educational underachievement and missed opportunities) are widely undiagnosed. [270] Screening at age 5 and through primary school years, with back-up service responses, are important. Peer rejection in middle childhood can predict association with antisocial peers and antisocial behaviour in adolescence. [271] However, many schools do not have sufficient access to resources to address trauma-related behaviour.

175. UK longitudinal research showed that the school community could be a key environment for improving outcomes for a population-based sample of children aged 5 to 13 who had been physically and emotionally maltreated. [272] Factors such as not being bullied, feeling satisfied with school, and engagement in extracurricular activities seemed to be protective and associated with later educational attainment (as evidenced by passing major school exams at age 16), and positive measures of self-esteem and wellbeing. The researchers noted that such factors are interlinking parts of a school's overall values and environment, such as policies on bullying, or provision of pastoral care or after-school activities.

176. Another school-level multi-intervention programme showed significant reductions in crime and improved wellbeing by age 25: a randomised controlled trial that included almost 1,000 children with conduct problems and other risk factors at around age 6 years (mean age 6.58 years, SD 0.48) had interventions throughout school and were then followed up at age 25 years. [273]

Programmes included training in parenting skills, with home visits and guided parent-child interactions, reading and peer-friendship groups, and when participants reached adolescence, they had both individual and family interventions, including some aimed at acquiring employment skills. Violence and crime were significantly lower in the intervention group, as were rates of psychiatric diagnoses and substance abuse. In terms of "breaking the cycle", it is interesting to note that those who had children themselves by age 25 were significantly less likely to approve of spanking children and had an increased sense of parenting efficacy, compared to controls.[273] As the authors emphasise, such research makes it imperative that evidence-based prevention is enacted (p. 68): [273]

The most important conclusion from this study is that a comprehensive, multicomponent developmental science-based intervention targeted toward early-starting conduct-problem children can significantly reduce adult psychopathology and violent crime. The findings run counter to claims that prevention fails, made by advocates of cuts to funding for prevention.

177. As noted in the second report in this series, a New Zealand programme of work on severely challenging behaviour and conduct problems in infants and children was researched and ready to go a decade ago, tackling many issues also relevant to children affected by family violence as they enter early childhood education or primary school (who are, of course, often the same children). [274] The *Implementation science* section below asks why intervening early, and effectively, seems to be so hard to do.

Intervene to lessen harm and prevent future risk: A trauma-informed approach

178. As well as making efforts to prevent early harm, we need good interventions for those already harmed, and to better manage child maltreatment and family violence effects. Children and families exposed to family violence and abuse face multiple issues that need diverse solutions, but a collaborative and coherent response, centred on the needs of the family, can be lacking (p. 21): [275]

Community agencies frequently work in their own service silos. They focus on their own mandates, services, and procedures with little understanding or consideration of the work of other agencies or the total experience a family has with all the involved service agencies and professionals.

Case study: Too many services

Nine-year-old Catalina is referred to child protective services because of bruises. Investigation reveals that her mother's boyfriend hit her with a belt and has done so before. He has also committed domestic violence on the mother with the last incident three years ago. He states that he hit her as ''spanking because she doesn't mind.'' The mother often yells at Catalina and threatens her for discipline. Catalina has behaviour problems and has been in trouble at school for fighting. The boyfriend is the father of two preschool children in the household. The mother was abused as a child and aged-out of the foster care system, and has been in therapy in the past for depression. Her child-welfare worker believes she may be using marijuana to ''self-medicate''. The mother and boyfriend are currently unemployed. They are in jeopardy of eviction from their current home. Catalina is in foster care; the two younger children remain in the home. (p. 10) [276]

"Business as usual" for this case could include involvement of many services – referral to child services for Catalina, maybe some "counselling", a mental-health assessment for mother, substance-abuse referrals, a parenting class, employment programme for mother and boyfriend, NGO referral for help with emergency housing, anger-management referrals. Too many appointments, too many assessments, and no-one's sure if Catalina and the two younger children are safe. Instead, a trauma-related assessment for Catalina and trauma-specific treatment, and referral to an evidence-based parenting intervention for parental violence (rather than vague "anger-management" programmes), plus a case manager who coordinates sustained, timely engagement with the whole family and service-providers, would be preferable.[276]

Interventions for those who have experienced trauma

179. Given the risk of intergenerational transmission of violence, it is essential that children who have experienced abuse and neglect or been exposed to family violence receive the support they need in order to reduce the likelihood of becoming, as adults, perpetrators or victims of violence themselves.

180. Children differ in their response to exposure to abuse and violence. As such, the first step to effective intervention lies in holistic, child-centred assessment of a particular child's risk and protective factors, followed by support and intervention that is tailored to these needs.[277, 278] Research shows the voices of children must be heard and directly included in this process, given that any decision is likely to impact their lives.[279]

181. Children make sense of violence in the family in different ways, according to their age and developmental stage, and their family and community circumstances. Some questions to explore may include:

    - How might children conceptualise violence – both directly experienced and seen – in terms of attributions, blame and consequences?
    - How does that vary according to age, both when at the time of exposure and when they receive interventions?
    - How does violence interact with other adversities in their lives, particularly direct maltreatment?
    - What coping strategies, positive and negative, do children of different ages employ?
    - How might they perceive the efforts – actual or perceived – of system professionals?
    - What does knowledge of these factors suggest for shaping interventions, specifically, what do we do, for whom, and when? (p. 5)[278]

182. Responses may be drawn from a continuum of primary, secondary, and tertiary services actions, ranging from short to long term, individual or group-based, and from directly working with the child to bolstering support for the non-abusing caregiver.[280] Working with the mother-child relationship may be particularly important.[281] In all cases, interventions must be specifically tailored and seek to foster stability within the child's world, including the family system to the extent this is safe.[282] Internationally, there is a move to trauma-informed practice that sees mental distress and "bad" behaviour as ways of surviving trauma (p. 179):[283]

> *Trauma-informed mental health services are strengths based: they reframe complex behaviour in terms of its function in helping survival and as a response to situational or relational triggers … Survivors in crisis are not viewed as manipulative, attention-seeking or destructive, but as trying to cope in the present moment using any available resource.*

183. By adolescence and young adulthood, those who have been exposed to chronic and ongoing abuse and neglect have often had input from various social, health and educational services, yet outcomes can remain poor. New Zealand research following almost 500 such youth over time showed the importance of a "positive youth development" approach in such services.[284] Rather than seeing young people as "broken", they must be seen as having undeveloped potential. Key aspects of a positive youth development approach include:

    - positive and sustained relationships with competent, caring adults
    - the development of life skills
    - opportunities for youth engagement and empowerment. (p. 202)[284]

184. This New Zealand research showed that, in line with the ecological definitions of resilience outlined above, rather than assuming the cumulative risks were overwhelming or that young people were unable or unwilling to engage with services, it was up to the professionals to form positive relationships; show respect for the young

person, their family and culture; and work on encouraging active involvement. This was not necessarily easy in fragmented services, that were not used to centring their practice on the diverse needs of young people, but showed the best outcomes over time on measures of educational involvement, prosocial behaviour, peer behaviour and life satisfaction.[284]

185. For adults who have experienced intimate partner violence, a recent review noted that "advocacy-based" help was common; for example, where a trained person engaged with the survivor/victim to provide support regarding the abuse/violence, safety planning and referrals to community resources, where available. [285] The advocacy approach was person-centred and strengths-based (that is, not "victim-blaming") and grounded in some sort of "empowerment" theory (such theory focuses on the person gaining or re-gaining control and increased autonomy for problem-solving/solution-seeking).

186. Of note, the research review showed that altering the distorted thinking and self-perception from the abuse was also important to allow more choices to seem possible (e.g., that the person was not to blame for the perpetrator's actions, or that sexual coercion or financial control were not "normal" in relationships). Psychoeducation about such ideas, the effects of violence, recovery from PTSD, positive parenting and so on was also common, often within other programmes. Therapeutic interventions were diverse, including individual cognitive and behavioural therapies, interpersonal therapy, support groups and multi-modalities, where, for example, advocacy and therapeutic interventions were combined, guided by empowerment and feminist principles. Interventions were seen as promising in reduction of violence, and facilitating and maintaining positive physical and mental health (depression and PTSD) changes.[285]

187. **Interventions for addictive behaviours**. It is important to note the cyclical effects of addictive behaviours – cyclical in that people engage in behaviour like alcohol and drug abuse or problem gambling as a way to manage the effects of child maltreatment and family violence (e.g., getting "out of it" to block distressing feelings or "self-medicate"), but this behaviour can then compound mental and emotional harm and in turn be a risk for parenting unsafely or perpetrating family violence.

188. For example, in New Zealand research, problem drinking was associated with an increased likelihood of current intimate partner violence and was found to be most significant when both the target of the violence and abusing partner had alcohol problems. [286]

189. Methamphetamine use has been associated with increased levels of aggression and violence [287] [288] and has been found to increase the probability level of violence from 10% during abstinence to 60% during heavy periods of use. [289] The level of violence ranges from altercations leading to physical violence to unprovoked violent attacks.[289] In addition, high levels of alcohol consumption have been found to increase aggressive behaviour amongst methamphetamine users.[288]

190. Addictive behaviour includes problem gambling; research shows that this too can have an association with intimate partner violence and family violence, though this is an under-researched area. Problem gamblers' children have reported financial and emotional deprivation, family conflict, parental neglect and abuse, and associated reduced security and stability. [290] A recent meta-analysis revealed that more than one third of problem gamblers report being victims (38.1%) or perpetrators (36.5%) of physical intimate partner violence with associated issues of less than full employment, impulsivity and anger problems, and alcohol and substance abuse. [291] What is apparent is that problem gambling, alcohol and substance use, mental-health problems, intimate partner violence and family violence can occur together, which reminds us of the importance of routine screening for such issues when an individual or family seeks help, and ensuring appropriate intervention services are widely available.

191. The impact of other drugs, untreated psychiatric and physical illnesses, and all the interventions needed could also be mentioned. It is beyond the scope of this discussion paper to cover everything required or to audit services available in New Zealand. Overall, however, there is a shift necessary to act against trauma in a *trauma-informed* way – to shift from piecemeal interventions and judgmental attitudes to respond more effectively.

Trauma-informed care

192. It is useful to distinguish between psychological interventions to treat the effects of trauma, such as trauma-focused cognitive-behavioural therapy, and "trauma-informed care". Specialist child and family services, mental health and psychological professionals provide the former; all of us can provide the latter.

193. ***Trauma-focused therapy.*** Around 15% of children and adolescents who have experienced abuse and trauma are diagnosed with post-traumatic stress disorder (PTSD).[292] Psychological trauma-focused treatments can produce large therapeutic effects; for example, trauma-focused CBT (TF-CBT) was found to be the most effective intervention in reducing PTSD symptoms in a recent meta-analysis (medium to large effect size).[293]

194. Trauma-focused CBT has flexible, structured components to work with children of different ages and together with parents/caregivers, so both build necessary skills. [294] For sexually abused children, research suggests that structured TF-CBT techniques have better treatment outcomes than use of unstructured play therapy strategies[295] and TF-CBT is also effective with survivors of intimate partner violence.[285]

195. ***Trauma-informed care*** is typically characterised as an agency's provision of a safe and supportive environment, acknowledgement of the prevalence of trauma among children and implementation of evidence-based practices to cater to the needs of such children.[296] As noted above, in the *Build workforce capability* section, it is an approach to service provision, rather than specifying exact components it must entail.[296]

196. While organisations and their staff generally acknowledge the importance of trauma-informed care, difficulties such as uncertainty regarding the everyday operationalisation of trauma-informed care at the coal face and limited training regarding how to care for traumatised children and youth remain common.[297]

197. This includes the need for more engagement and awareness of the "intergenerational impact of violence upon whānau, hapū and iwi, and the subsequent manifestation of that in individual behaviours" (p. 48[298]), so as to enact complex, historical trauma-informed care for Māori, as led by Māori. As researchers point out, "A Māori-specific Trauma Informed Care approach follows from models like Whare Tapa Wha, providing detail in the form of principles of practice that can guide Māori and non-Māori practitioners in working effectively and competently with tangata Māori" (p. 25).[298]

198. It has been suggested that there is nothing inherently special about trauma-informed care, given that all care within child-welfare services ought to be safe, supportive, and responding to a child's needs.[296] But the key is that this needs to extend beyond child-welfare services – it is a unified, inter-sector trauma-informed care response (e.g., across education, child welfare, health, justice, community and social services) that is likely to most appropriately meet the needs of children and adults who have been exposed to violence and abuse.[297] In other words, there is a need for a *systemic* trauma-informed care approach that understands how trauma affects the behaviour, health and wellbeing of children, parents and disadvantaged communities.[299]

199. Such a systemic approach could be underpinned by the recently released "Power Threat Meaning Framework". [300] From lawyers and police to mental health professionals and GPs, the framework helps us think about family violence and child maltreatment as means by which power plays out in threatening ways that we try to make sense of and do what we must to survive:

- What has happened to you? *(How is power operating in your life?)*
- How did it affect you? (*What kind of threats does this pose?*)
- What sense did you make of it? *(What is the meaning of these situations and experiences to you?)*
- What did you have to do to survive? *(What kinds of threat response are you using?).* (p. 8)

200. That is, "power" over children or partners is in operation in family violence, which threatens mental and physical wellbeing in myriad ways, as we have already noted; children make sense of such experiences as best they can (including assuming that they are to blame, that they are inherently bad or useless, and that they, too, will have to be violent to survive); and the survival "threat responses" can include anything from the fight/flight/freeze response, dissociation, shame, self-harm and suicide, rage (and criminal offending), substance use, mental-health issues and so on.

201. Being trauma-informed reminds us that an important emotional consequence of child maltreatment are feelings of shame and guilt. Even though the responsibility for the violence, abuse and neglect lies with the perpetrators and those who failed to protect the child, the child is left with a sense of shame, often experienced as a wish to hide their "damaged" self from others. The shame has been linked to elevated symptoms of PTSD and depression in adolescence and beyond, with enduring thoughts like, "What happened to me makes me feel dirty" and "I feel ashamed because I think that people can tell from looking at me what happened" (p. 340).[301] Where a woman has experienced childhood maltreatment, there can be concern as to how having a baby will revive that sense of shame in a way that interferes with maternal wellbeing postpartum, maternal bonding and parenting behaviours, and thus infant development. Research shows that, compared to non-abused women, those who had experienced more maltreatment had higher feelings of shame, which may mediate their higher risks of postpartum depression and PTSD.[302] This points to health providers' need for "trauma-informed care" to understand the lifelong - and potentially intergenerational - impacts of child maltreatment at key times of life.

202. Trauma-informed care also applies to work with intimate partner violence, most crucially having an understanding that if people had learned how to behave differently, they would. In New Zealand rehabilitation work with very violent couples, seen to be at risk of "killing each other", it was important to understand the "highly volatile moments where men and women are desperately weak, desperately wanting something, but don't know how to articulate it" (as justice expert, the late Celia Lashlie, put it).[303]

Interventions with perpetrators

203. As the victim-offender cycle highlights, early intervention and trauma-informed care with maltreated children is a way of dealing with the violence perpetrators of tomorrow, the vast majority of whom have experienced violence as children themselves. However, until this happens, we need to figure out how better to work with perpetrators of family violence to stop their offending.

204. As with other types of offending, deterrence is largely ineffective – even when in prison, a perpetrator can threaten and harass a partner, or get community associates to do so.[304] Putting a perpetrator in a police cell overnight does not mean his family is safe the next day, and there are inadequate services for long-term behavioural change and the necessary accountability for his actions. Relationship and parenting skills, substance-abuse and mental-health treatment, restorative-justice processes and other appropriate services may be required, as well as adequate services for all those harmed. Instead, responses in New Zealand are seen as "piecemeal and insufficient, and mired in a complex web of bureaucracy" (p. 1).[305]

205. As with those experiencing family violence, perpetrators are diverse, with some self-referring for non-violence programmes (which are mostly unfunded for self-referrals, having to instead deal with those mandated for treatment) through to high-risk recidivists

who see nothing wrong with their behaviour. Services do not coordinate well when contact between perpetrators, victims and families resume after an episode of violence.[305]

206. It is easy to simply blame a perpetrator without taking responsibility for our role as a community members - for not attending to the emotional, psychological and other types of harm going on in the relationships of our friends, family/whānau or neighbours; for our outdated social norms about how men and women should behave in relationships; or for the lack of preventive, childhood supports that would have made it less likely for them to end up as adult perpetrators and/or victims; that is, that their current violence is a symptom of past maltreatment.

207. We currently lack a comprehensive and coherent response to both perpetrators and victims - a New Zealand issues paper highlights the need for integrated systems that:

- are built from the perspective of system users, not individual service providers
- include crisis services but also continue to provide support until change is firmly established
- include response sub-systems that cater for perpetrators, victims and families
- require more New Zealand research before any redesign proceeds, because good design requires knowledge about service users, and about current responses, which is currently lacking
- recognise our communities hold expertise that is important to harness in any redesign. More researcher-practitioner collaboration should be built into any ongoing research and evaluation, because evidence-based practice is a process, not an outcome. Victims and victim advocates also hold expertise that is valuable to this research
- include co-ordination between crisis response and immediate containment, criminal and civil court proceedings, sentence or order compliance, risk monitoring and behaviour change components, and provides services based on risk and need. (p. 1).[305]

Predicting risk to prevent harm

208. Although no one risk factor can reliably predict the future antisocial behaviour of an individual in isolation, a higher number of risk factors is likely to increase the probability that a child will engage in antisocial behaviour, including violence.[306] Although the origins of severely challenging behaviour problems are complex, we need to focus on – and modify – the environmental factors that exacerbate them, to stop the flow of those who will engage in child maltreatment and family violence in the future.[307] [308] [309]

209. Predicting risk is part of trying to intervene early and effectively – but is extremely difficult.[310] Notifications of suspected child maltreatment are dealt with by child-welfare staff (such as at Oranga Tamariki in New Zealand) in complex circumstances, where either removing children from their home or letting them remain may both have negative outcomes. Approaches to risk assessment range from standardised risk assessments (based on statistical links between risk factors and maltreatment) to unstructured "clinical judgement", or a mix of the two (where some standard risk factor measures are used, along with professional, team and case-management assessments). A recent meta-analysis endorsed standardised assessments as more evidence-based, but the researchers acknowledged that the predictive power of such assessments was still limited by the lack of well-validated assessment tools that have been developed and tested.[310]

210. Also, as discussed elsewhere in this report, it is impossible to simply map some family-violence risk factors onto a specific outcome of harm, given all the complex interactions of individual, family, community and circumstantial influences that occur to worsen or reduce risk. The Integrated Data Infrastructure (IDI) programme within Statistics New Zealand draws together anonymised data on interactions with government services (education, health, justice, social development etc.)[311] Ideally, this should be used as a research tool at a population level to underpin the workforce-planning and resourcing needed for those groups identified as most at risk.

211. Resources like the IDI may provide more of the "actuarial" data required to build better risk prediction tools, including with a basis in local cultural values and experiences, but we must also maintain a common-sense approach. We do not need to wait for extensive data to know that doing a good assessment – with awareness of the possibility of family violence and maltreatment – in any situation where a child or family have come to the attention of a community or state agency (e.g., health, education, police, justice) – and having adequate, skilled responses from well-resourced staff, available in a timely manner to deal with this, are critical.

Use of technology

212. One of the challenges identified in child-maltreatment research is the research-to-practice gap, as families in need are often "hard to reach" (mostly because services have such limited reach) and, therefore, they do not receive the support they need. Technology may have a limited role in increasing some client's access and engagement with evidence-based interventions within the child-welfare system,[312] while also holding in mind the necessity of kanohi ki te kanohi (face-to-face) for Māori and other cultural considerations in applying such evidence.[313]

213. The addition of text reminders regarding parenting strategies to "parent-child interaction training" (PCIT) has been shown to have positive effects [314] and there is evidence that parents, including low-income, "at risk" families, will use mobile or internet interventions as part of programmes designed to support their parenting.[315]

214. A randomised control trial showed higher engagement rates with an internet intervention than some home-visitation programmes demonstrate, perhaps due to their increased flexibility relative to home-visitation programmes. Furthermore, parents with higher rates of engagement with the internet intervention demonstrated better parenting behaviour than those with lower engagement (i.e., there was a dose effect).[316] The use of technology (e.g., videos) to supplement parenting interventions has shown mixed results: although educational videos have been shown to reduce training burden (less time spent on training new skills with at-risk parents),[317] they did not affect risk factors for child maltreatment or child-maltreatment outcomes at 6- or 12-months follow-up.[318]

215. There is preliminary evidence from a small US pilot study that delivering trauma-focused cognitive-behavioural therapy (TF-CBT) via videoconferencing may reduce post-traumatic stress symptoms in adolescents.[319] The researchers argue that such findings are promising given that at-risk youth and their families are often hard to reach with more traditional interventions, but this should not be seen as a cheap alternative to normal TF-CBT. A full face-to-face assessment still had to be conducted with the 15 participants (aged 12 to 17) and their caregivers to confirm eligibility; where school-based video-conferencing equipment was used, relationships were established with school-guidance staff, who had to be available for follow-up after the psychoeducation and therapy sessions, or caregivers had to be home when home-based videoconferencing was done; and the work took up to 19 sessions of 45 to 90 minutes each with each young person. That is, the cost savings were primarily because the youth and their caregivers did not have to travel to the clinician's office, rather than because less clinician time was required.

216. A New Zealand randomised controlled trial of a web-based safety decision-making tool for women experiencing intimate partner violence is underway, which gives participants access to a safety priority-setting tool (to rate the often-competing priorities of children's wellbeing, feelings for partner, their own safety, resources such as housing and income, and privacy); a danger assessment (rating 19 aspects of risk and lethality and how often they have occurred on a calendar); and an individually tailored safety action plan (based on the information they have entered).[320] The trial aims to show that there is reduced exposure to intimate partner violence and improved mental health in those using the tool, compared to those

who receive usual safety-planning resources (family violence contact numbers, a general emergency action plan etc).

217. An increasingly substantial issue to monitor is the use of technology to enact violence, especially intimate partner violence, harassment, and sexual offending against adults and children.[321]

1.4 Why is implementation science so important?

218. Transforming New Zealand's family-violence and child-maltreatment statistics needs to be more than just evidence-based programmes – it is also about understanding what are the key ingredients of successful implementation of such programmes. How do we sustain change, beyond just the next political or funding cycle? How do we take to a wider scale what works for the children who can benefit the most? How do we, as a community, agree that violence has to stop?

219. Successfully intervening in the family-violence area is challenging. Inspired, effective leadership is lacking. Worldwide, public services addressing child maltreatment are often poor and very few adhere to evidence-based practices.[322] Social and child-welfare services are mostly chronically underfunded, resulting in a workforce that is under-resourced and overworked, with families not receiving the necessary and adequate care they require. Unfortunately, New Zealand is no exception to the global picture. As a long-term advocate of evidence-based, child-maltreatment care lamented, "When offering *any* care is a stretch, high-quality care may seem an unattainable goal" (p. 107).[322]

220. A large body of research has identified a range of evidence-based programmes that policy-makers and agencies may draw on to improve systems, practices and subsequently outcomes for children and families;[322] however, data regarding effective *implementation* of evidence-based practice within the child-welfare sector remains scarce[323] and, relative to youth-justice and mental-health systems, the adoption of evidence-based practices within the child-welfare system has been limited.[324]

221. "Implementation science" explores the ways we can put evidence of a promising programme or approach into sustainable, day-to-day practice.[325] It tries to share ideas on what gets in the way of good practice (the barriers) and what seems to help. It highlights how the different contexts of organisation, policy and funding must be seen as "front and centre" of implementation, as otherwise evidence-based practice from carefully controlled and well-funded research trials are hampered by poor real-world implementation,[322] and innovative, culturally responsive, real-world programmes are never taken to needed scale. That can mean that more women and children die, as a participant in Māori primary prevention research points out - we cannot always afford to keep waiting (p. 21):[326]

> *We can't afford to wait until we know everything. We are never going to know everything. We need to do something. Take action. Give it our best guess at the time. Our women are worth it. Our children are worth it.*

222. Research shows that successful implementation depends on a number of "inner setting" and "outer setting" factors:[327]

- *Inner settings*: organisational structure, organisational culture, implementation climate, organisational readiness for change, leadership, staff turnover, staff capability, communication
- *Outer settings*: broader socioeconomic and political factors
- Development of "learning organisations", that are dynamic and able to adopt new practices according to new evidence, is essential.

223. Similarly, the widely referenced EPIS conceptual framework (Exploration, Preparation, Implementation, and Sustainability) describes inner-context factors (leadership, agency characteristics, and staff attitudes) and outer variables such

as overall service environment, political climate, and funding, that affect the implementation of evidence-based policies in child welfare and other public health sectors. [328] Developing strong implementation leadership at all levels, including at the policy level, is critical.[329]

224. In the area of child welfare and family violence, there is even more of an ethical duty to ensure that effective interventions are offered, especially where intervention is mandated by the state (as in care-and-protection actions, or mandated perpetrator-treatment programmes) (p. 22): [330]

Referring families to services with unknown or even questionable efficacy is at best a waste of time and an unnecessary burden on families. More concerning, these services can do great harm. When serious decisions are made based on poor outcomes due to ineffectual services, harm is much more likely.

Equally problematic is the strong likelihood that many children and families will become "inoculated" against participating in any future services by being forced to go to poor ones. Families may be more reluctant to engage in highly effective services because their prior experiences have been so unhelpful.

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225. Research also highlights the importance of active engagement and flexible consultation and co-design processes with stakeholders (from families and workers to policy-makers and funders) and extended peer review to increase buy-in toward adoption of evidence-based approaches. For example, initial consultation was found to be crucial in a large-scale, early-intervention and prevention initiative that added five evidence-based programmes for families and children (birth to 20 years) to routine child and family services in a disadvantaged area in Ireland. [331] The programmes ranged from pregnancy and birth support to parenting, education, literacy and youth mental-health and wellbeing initiatives. Their "planning process framework" was as follows. Note that the consultation starts with the community and ends with the politicians, and that all this occurs before any programme is begun: [331]

1. Capture the "community voice" (i.e., consultations with local residents and community leaders)
2. Capture "children's voices" (i.e., consultations with children and young people)
3. Audit existing services within the community
4. Review existing evidence of what works (i.e., identify evidence-based services)
5. Conduct a local needs analysis
6. Review evidence of existing need
7. Review the national policy context
8. Engage with key stakeholders and decision makers. (p. 190)

We must ensure that we capture the voices of those who are least often heard from, as opposed to primarily the powerful and the political.

226. A review of implementation frameworks found six key factors that underlie successful implementation of evidence-based work: process (e.g., staff selection, training, performance assessment), provider (e.g., views of the intervention), innovation (e.g., complexity, adaptability, and cost of implementation), client/service-user (e.g., buy-in to the intervention), organisational (e.g., culture, climate, values), and structural (influence of stakeholders and policy).[332]

227. Similarly, a 2016 comparison between a successful and a failed implementation of an evidence-based parenting intervention within the child-welfare system found that the critical factors were high-quality training, funding (for the intervention itself as well as to reduce burden on staff facing increased workload), flexibility, the practical nature of the intervention, good leadership, and cooperation with external stakeholders and the broader environment.[333]

228. Barriers to the implementation of evidence-based programmes include:

- High rates of staff turnover in social-welfare services which can affect the value of training staff in new programmes[334] [335]
- Service administrators/managers see the cost of training and time as key implementation barriers[336]
- The challenge of how to implement programmes generally and particularly at the scale necessary to achieve maximum impact[322]
- Political factors – it can be politically useful to introduce programmes but not necessarily to rigorously evaluate them over time.[337]

229. Further factors that have been identified as critical for implementation include:[338]
    - Acceptance by caseworkers and the family/service-users
    - Match between the programme and family needs, and understanding of what will get in the way of change (both system and family factors)
    - Attitude of caseworker towards implementing the evidence-based programme
    - Caseworkers' experiences of training in the programme
    - Organisational support of the programme
    - The overall impact of the programme on outcomes and service.

230. For example, the evidence-based Triple P parenting programme has been applied in New Zealand communities, including with Māori.[242] US research noted that high-quality training of staff was crucial, making practitioners confident they had learned the methods and approach at training completion, and that the programme could effectively change family functioning.[339] Also critical were managerial and organisational expectations of full programme use – that is, leadership and support from the top to ensure families were really helped.

231. A *system* of prevention and intervention is needed, not just individual activities that happen (or, often, do not happen) just one child or one family at a time. Evidence-based questions can be too narrow – that is, just asking, "What works to improve outcomes for the targeted group?" and measuring average effects, instead of knowing what works well for which participants; asking how children and families and staff experience the programme; asking why they do (or do not) engage with it; and asking what meaning it has in their lives.[340] External validity – where findings from a researched programme are generalisable to real-world settings – can be hard to achieve, especially if a "one-size-fits-all" application is to be avoided.[341] There are concerns that we too often measure only outputs – not outcomes – in the family-violence area; that is, measuring numbers who participate in a programme, rather than how their lives are transformed by it.[342]

232. In addition, an evidence base does not necessarily persuade decision-makers in government or organisations to change policy or practice accordingly.[340] Too often, political ideology and electoral considerations can outweigh evidence. Decades of insistence on New Zealand's failed criminal-justice policies of deterrence and incarceration, without effective impact on recidivism, are testament to that. [343] There are increasing calls internationally to build relationships of trust between the producers and consumers of evidence in this field, so that meaningful questions are asked and answered, and effective research-practice-policy partnerships developed[344] – this has been a long-standing call from kaupapa Māori researchers.

233. Furthermore, a key barrier to effective implementation can be the need for *social change* – evidence-based interventions are not enough to get at the root of the social problems that caused the need for the intervention in the first place.[340] It is all very well to help a maltreated child recover from trauma and perhaps engage better in school, but when entrenched social structures of racism, low-wage employment, and a lack of sustained social services or accessible mental-health care hamper the life-course opportunities that began the cycle of abuse in the first place, little has been truly changed.

Emerging and promising practice

234. Social research often has to move far outside the tidy world of randomised controlled trials that can operate in establishing the efficacy of medical therapies or projects with rats or plants. For example, there would never be ethics approval to randomise some babies to a violent home and others to a non-violent one. Human life is extremely complex and multifaceted, including in the area of family violence; [345] research methods and intervention approaches need to be similarly diverse – and flexible.

235. More "contextualisation" of child-maltreatment research is called for, seen as key to robust prevention and intervention, particularly in understanding the impact of social and cultural contexts of families and communities on experiences of family violence and on interventions.[341] Qualitative methods, case studies, mixed-methods research, "stories of most significant change", integrated data approaches and other forms of data have much to contribute. Indigenous models of knowledge and research must be recognised. In the early-childhood field, *The Lancet* notes that, although randomised controlled trials (RCT) are important, so is practical, community-level and cultural knowledge and implementation (p. 15): [346]

> *Equally important [to the RCT] is the role of practical, community-level knowledge embedded in cultural beliefs and child-rearing practices that influence nurturing care, and the insights it provides about what works for whom and why in different contexts….*
>
> *This requires a dynamic learning community that is able to integrate intervention statistics with developmental biology, technical and practical expertise in programme implementation, and context-specific knowledge and priorities.*

236. Similarly, in research with adults, there are challenges in trying to apply traditional experimental research methods. For example, in reviewing interventions with women affected by intimate partner violence, reviewers noted that study sample sizes were often small, study drop-out was high and long-term follow-up difficult, given that the women were often in emergency refuges or shelters and often in the process of needing to relocate.[285] There were also ethical and safety constraints and difficulties completing interventions (for example, needing to leave the refuge after only a few therapy sessions had been arranged). The authors recommend that community-based participatory research, where research is led by community members, support organisations and researchers in collaboration, would potentially develop more feasible and real-world methods and outcomes.

237. There is also concern that appropriate evaluation methods must be used to assess the success of programmes. US evaluation models dominate the field; we need to ensure local values and models are skilfully employed, especially Māori[57] and Pacific.[63]

238. There is a significant gap in available funding for researchers on family violence and child maltreatment. The impact of this is that we fail to grow local knowledge about our local needs. There is a need for research funding systems to change and be targeted at family violence and child maltreatment for tertiary and other research institutions.

239. In reviewing what has helped improve good practice in the child-maltreatment field over 40 years, the *Child Maltreatment* journal noted the role of "emerging implementation research" as crucial, alongside having committed leaders who can access the resources needed to really support change; having the necessary changes in skills and attitudes from co-workers and supervisors; and establishing alignment with organisational policy. The community context, including regulatory and funding systems, referral sources and the legal system, and the attitudes of the media and general public, also affect success, along with a lot of careful thinking and learning from practical experience in the process.[347]

Concluding comments

Preventing family violence is very simple and very complicated. Day-to-day, it's about not ignoring the way your friend's partner behaves towards her, or not judging the disruptive kid at school and just wanting him kicked out. But it's also about reflecting on our beliefs about relationships; who is responsible for family wellbeing in our communities; and how public and private resources should be applied.

It should be simple to take note of implementation science: start with the needs of children and families at the centre, and work out how to meet them, guided by evidence from science and real-world experience. But New Zealand is poorly served in this regard. There is little implementation science. It is complicated to wrangle systems and services, currently measured by individual outputs, to have to work together to meet those needs, and to ensure sustained leadership get staff trained and supported to work well across sectors and diverse communities.

This series of reports relates to the criminal-justice system. Talking about the wellbeing of babies seems a long way from arguments about the prison muster, but that is where the evidence says we must begin.

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