yourtown
POWERING kids helpline

what works?

Domestic and family violence support

January 2023

For more information contact:
research@yourtown.com.au

purpose

This paper provides a summary of evidence relating to what works regarding young parents experiencing domestic and family violence.

The evidence is centred around what works to meet the needs of a parent, aged 15-24, requiring either general parenting support or help due to domestic and family violence. Safety and security vulnerability factors include having experienced sexual assault, unstable living arrangements, and domestic and family violence and neglect of needs. Mental wellbeing vulnerability factors include relationships and social isolation (Figure 1).

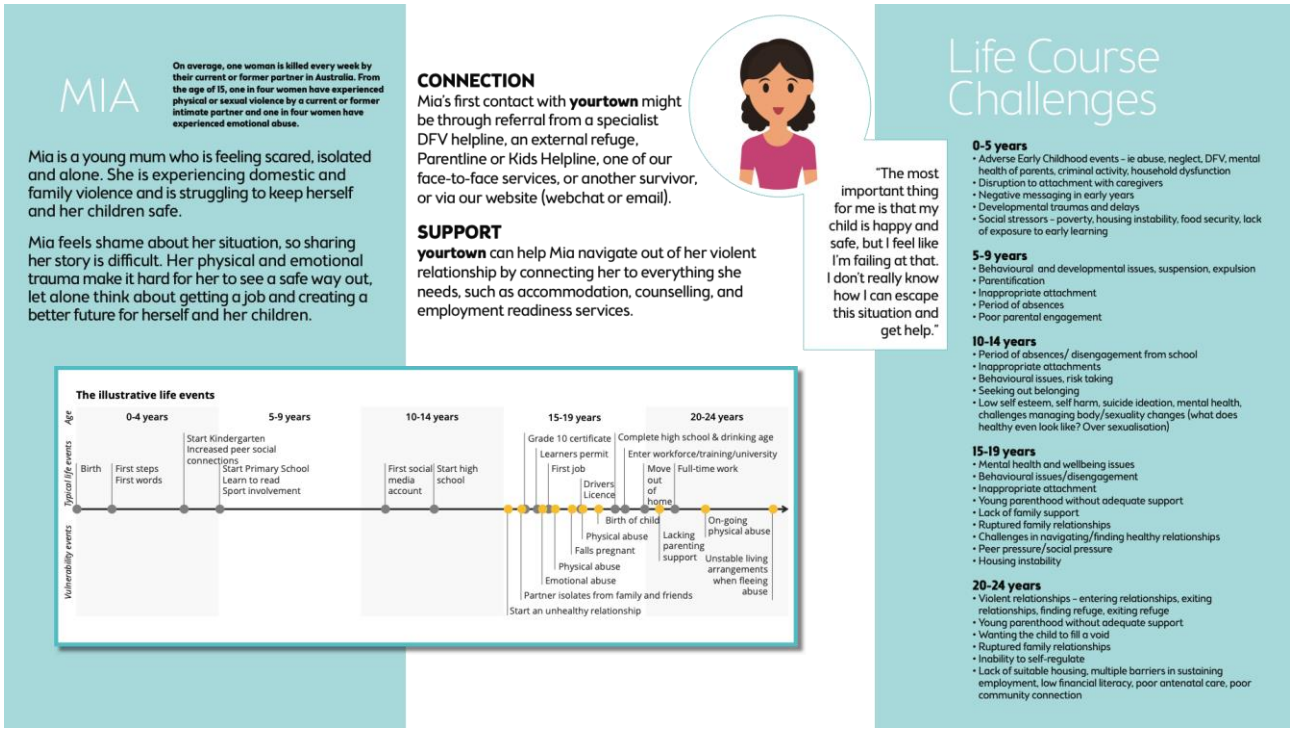

Figure 1.

background

Family violence occurs between family members (e.g. parents, children, siblings) as well as non-family carers who are violent against people they are caring for. Domestic violence is a type of family violence that is perpetrated by current or former intimate partners [1]. Domestic and family violence can include physical violence, sexual violence, emotional abuse, and/or coercive control[1]. These forms of violence can be rare occurrences or a pattern of abuse over time. They can also be overt behaviours, attempted behaviours and/or threats [2].

Young women are at greater risk of domestic violence. They were also among specific populations who were more at risk of experiencing physical and sexual violence and coercive control during the first six months of the COVID-19 pandemic [3]. Other population groups that are disproportionately affected by domestic violence include Aboriginal and Torres Strait Islander women, pregnant women, those with high financial stress, women with long-term health conditions, and people who experienced family violence in their childhood or were exposed to their parent experiencing domestic violence.

In 2016, almost 1 in 4 (23% or 2.2 million) women and 1 in 13 (7.8% or 704,000) men experienced physical and/or sexual violence by an intimate partner at least once since the age of 15.[2] An estimated 2.3% (or 212,000) of women and 1.3% (or 114,000) of men experienced physical and/or sexual intimate partner violence at least once in the 12 months prior to the 2016 Australian Bureau of Statistics Personal Safety Survey (ABS PSS).[3] In 2019-20 women were the victims in 36 of the 45 intimate partner homicides (80%) and men the victims in nine incidents.[4] The data indicates of cases where violence occurs between intimate partners are where women are the ones experiencing violence. The current research reflects this and therefore a large proportion of the research regarding domestic and family violence interventions are focused on women.

Further, in 2016 almost 1 in 4 females (23% or 2.2 million) and 1 in 6 males (16% or 1.4 million) had experienced partner emotional abuse since the age of 15.[5] With almost 1 in 5 women (18% or 1.7 million) and almost 1 in 20 men (4.7% or 429,000) having experienced sexual violence at least once since the age of 15.[6]

People who have experienced domestic violence can have "multiple and competing negative psychosocial concerns, including the protection and care of children, physical health concerns, safety concerns, financial instability, legal proceedings, feelings of isolation and lack of social support, low self-esteem and feelings of grief, and managing ongoing threats from and relations with abusers, as well as ongoing trauma and psychological symptoms" [4]. Mental health concerns are common among people who have experienced violence [5], and comorbidities can occur with mental health issues such as depression, anxiety, and post traumatic stress disorder (PTSD) [6].

[1] Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, frighten, subjugate, or deny autonomy. See Women's Aid Federation of England. 2022. What is coercive control? (https://www.womensaid.org.uk/informationsupport/what-is-domestic-abuse/coercive-control/)
[2] Australian Institute of Health and Welfare. (2022). *Family, domestic and sexual violence data in Australia.* Retrieved from (https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-data).
[3] *Ibid*
[4] Serpell B, Sullivan T & Doherty L 2022. Homicide in Australia 2019-20. Statistical Report no. 39. Canberra: Australian Institute of Criminology (https://doi.org/10.52922/sr78511).
[5] Australian Institute of Health and Welfare. (2022). *Family, domestic and sexual violence data in Australia.* Retrieved from (https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-data).
[6] Australian Institute of Health and Welfare. (2022). *Family, domestic and sexual violence data in Australia.* Retrieved from (https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-data).

Domestic and family violence among women during the COVID-19 pandemic

Recent data supports the early anecdotal reports that people experiencing domestic and family violence were at even greater risk during the COVID-19 pandemic, particularly during lockdowns when they were forced to spend more time at home with perpetrators and were limited in ways to safely seek and access support. Younger women, Aboriginal and Torres Strait Islander women, pregnant women, those with high financial stress, and women with long-term health conditions were more likely to experience domestic violence during the pandemic [7].

In an online survey of almost 8,000 of Australian women who were in a cohabiting relationship, 13.2 per cent had experienced physical violence, sexual violence, or coercive control from their partner during the initial stages of the pandemic in 2020. A small cohort of women experienced violence from their partner for the first time. Among the women who experienced physical or sexual violence during the pandemic, one-third stated it was the first time they had experience violence from their partner. Further, 19.9 per cent of the women who reported experiencing coercive control during the first part of the pandemic in 2020 stated that it was the first time their partner behaved in this manner against them [7].

More than half (53 per cent) of the women who had experienced violence from their cohabiting partner reported an increase on the frequency or severity of physical or sexual violence during the pandemic. Almost half (47 per cent) of the women who experienced ongoing emotionally abusive, harassing or controlling behaviours from their cohabiting partner stated that these behaviours had increased in frequency or severity during COVID-19 [7].

A rights-based approach to preventing domestic and family violence

Domestic and family violence is a human rights violation [8]. Under the United Nations *Convention on the Elimination of All Forms of Discrimination against Women*, member countries that are required to implement the necessary strategies and supports to end violence against women [9]. A rights-based approach involves the following core components:

- Developing the capacities of those who are responsible for protecting and supporting parents and children who are experiencing domestic and family violence.
- Developing the capacity of parents experiencing domestic and family violence so they increase the safety of themselves and their children [10].

While there is no single intervention that works for all parents experiencing domestic and family violence, evidence-based initiatives that are most effective share many common features. The interventions explored below follow the widely accepted approach of targeted therapeutic care that is implemented after immediate crisis interventions have ensured people who have experienced violence are safe and their situation has stabilised [4].

what works?

Contemporary evidence indicates there is good, emerging, and limited evidence for the following components of interventions relevant to a child or young person, aged 5-25, who requires mental wellbeing support.

Quality of evidence is assessed as follows:

 Good Evidence[7]

 Emerging Evidence[8]

 Limited Evidence[9]

[7] Evidence is considered good if: a systematic review or meta-analysis has a strong quality assessment rating and includes at least 5 primary studies or narrative synthesis has a quality assessment rating of 9+ and recent primary studies are in line with review findings.

Note: When there is good evidence that an intervention is generally successful, this does not mean that each intervention within this space has good evidence. However, it does indicate fewer concerns about the program's theory of change.

[8] Evidence is considered emerging if: only narrative synthesis on the intervention is available.

Note: When there is emerging evidence, generalisability of results is limited as there is limited evidence. While some interventions of a particular type have encouraging results, more research is required to understand the effectiveness of the internet. Rigorous, medium-sized trials are required to better understand the potential of the intervention.

[9] Evidence is considered limited if: there is an absence of strong research on the intervention.

features of interventions

Feature	Quality of evidence
Consistent social support decreases family violence Social support over extended periods of time is critical in moving people away from their violent situations. Support should be delivered by a dedicated case worker so that the people experiencing violence do not need to repeat their stories during their care and become apathetic with the process **[11]**. Informal social support for women who have experienced violence can arise from the development of positive links to other individuals or groups **[4]**.	
Psychosocial interventions can facilitate improvements in mental health Interventions that teach skills such as problem solving and decision making competence, goal setting, negotiation, and setting boundaries, can improve mental health of women who have experienced mental health. In addition, stress management practices such as breathing techniques, muscle relaxation, and mindfulness can improve mental health **[4]**.	
Interventions that take a holistic approach can lead to improved outcomes across a range of issues Women in domestic violence refuges often have complex needs, such as substance abuse and complex mental health issues. Services that have established and trusted relationships with other services can expedite access to support and address various issues concurrently **[4]**.	
Individually delivered therapies are more effective than group interventions Women who participate in one-on-one therapy, in comparison to those who participate in group therapy, are more likely to gain benefits in PTSD, self-esteem, depression, general distress, life functioning, and emotional wellbeing. This may be due to the individually delivered therapies being tailored to meet the unique needs of individuals who have varying experiences of domestic violence **[12]**.	
Tailored programs are more effective than universal programs Treatments and therapies that are tailored to people who have experienced domestic violence and their changing situations and evolving needs are more likely than universal or generalised programs to gain positive outcomes such as reduced PTSD, depression, and general distress, as well as increased self-esteem, life functioning, and emotional wellbeing **[13]**.	
Interventions should be culturally sensitive Interventions should account for the cultural beliefs and language barriers of people who have experienced violence, by having resources in different languages, accessing interpreters, and having staff who are bilingual and/or have participated in cultural awareness training. This will increase trust and engagement with interventions **[12] [14]**.	

Feature	Quality of evidence
Increased frequency and amount of time in therapy increases its effectiveness Therapy that is conducted for at least 10 sessions is more likely to improve the mental health of women who have experienced violence. The multifaceted issues faced by women who have experienced violence is more likely to be addressed through more time participating in therapy and interventions **[12]**.	
Time limited therapies should be supplemented with follow up sessions Women in shelters who have improved mental health are more likely to maintain these benefits when their brief therapies are supplemented with follow up or booster sessions **[12]**.	
Violence reduction and safety programs are effective Programs are effective in decreasing violence and increasing safety in relationships by providing information about safe places and shelters, help-seeking, and protecting oneself from and after a violent incident **[5]**.	

Advocacy/case management interventions

Feature	Quality of evidence
Advocacy/case management interventions can increase mental health outcomes and social support access Community-based advocacy/case management interventions involve helping people who have experienced violence to access resources and supportive relationships. These interventions can be delivered by mentors or case managers in the home of clinic. The results are a decrease in depression, fear, and PTSD, as well as increase in social support **[15]**.	
Advocacy/case management interventions that are delivered remotely can improve mental health outcomes There is no significant difference between remote and in-person delivery of advocacy/case management interventions on mental health (depression, fear, and PTSD) and social support outcomes **[15]**.	
Advocacy/case management interventions can help increase the safety of women who present to Emergency Departments due to domestic violence There is emerging evidence that women in hospital Emergency Departments due to injuries from experiencing domestic violence can benefit from access to advocacy/case management workers. The main role of these workers is to increase the safety of the women who have experienced violence through developing safety plans, providing referrals to community services, and liaising with judicial services **[16]**.	

therapies designed to manage psychological effects

Feature	Quality of evidence
Psychological interventions are effective in reducing decreasing depressive symptoms Cognitive Behaviour Therapy (CBT) that is supplemented with interventions such as expressive writing and trauma-informed approaches are more likely to lower depressive symptoms compared to treatments that do not include these added interventions **[5]**.	
CBT-based therapies and interpersonal therapies gain better outcomes CBT-based treatments and interpersonal therapy addressing current situational factors that are tailored to people who have experience intimate partner violence are most likely to gain outcomes regarding PTSD, self-esteem, depression, general distress, life functioning, and emotional wellbeing **[13]**.	
Trauma-informed therapies are more effective when they are adapted to the changing situations and needs of women who have experienced domestic violence Trauma-informed therapies that focus on specific stressors are particularly effective at decreasing anxiety and increasing sense of control of women in shelters. These therapies are have better outcomes for women compared to programs and treatments that work towards predetermined outcomes **[12]**.	
Cognitive trauma therapy can improve PTSD symptoms in women who have experienced domestic violence PTSD symptoms improve after participation in therapy tailored to women who have previously experienced violence. This cognitive trauma therapy focuses on PTSD psychoeducation, stress management, exposure, (discussing the specific trauma), trauma-related guilt regarding effects on children and decisions to stay or leave, other traumatic experiences, potential contact with the person who perpetrated the violence, and strategies to deal with victimisation. These improvement in symptoms occurred after treatment and were maintained for three months **[17]**.	

references

[1] Australian Institute of Health and Welfare, "Family, domestic and sexual violence," 2022. [Online]. Available: https://www.aihw.gov.au/reports/domestic-violence/family-domestic-and-sexual-violence.

[2] Victorian Government, "What is family violence?," 2021. [Online]. Available: https://www.vic.gov.au/what-family-violence.

[3] H. &. M. A. Boxhall, "Who is most at risk of phsyical and sexual partner violence and coercive control during the COVID-19 pandemic?," *Trends & Issues in Crime and Criminal Justice,* vol. no. 618, 2021.

[4] S. Paphitis, A. Bentley, D. Osrin and S. Oram, "Improving the mental health of women intimate partner violence survivors: Findings from a realist review of psychosocial interventions.," *PLoS ONE,* 2022.

[5] G. Karakurt, P. Katta, N. Jones and S. Bolen, "Treatments for female victims of intimate partner violence: Systematic review and meta-analysis," *Front. Pyschol.,* vol. 13, pp. 1-13, 2022.

[6] World Health Organization, "Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence.," World Health Organisation, 2013.

[7] H. Boxhall, A. Morgan and R. Brown, "The prevalence of domestic violence among women during the COVID-19 pandemic.," *Australian Institute of Criminology Statistical Bulletin,* vol. 28, 2020.

[8] United Nations, *Declaration on the Emilination of Violence against Women,* 1993.

[9] United Nations, *Convention on the Elimination of All Forms of Discrimination against Women,* 1979.

[10] United Nations Women Virtual Knowledge Centre to End Violence against Women and Girls, "Adopting a human rights-based approach," 2010. [Online]. Available: https://www.endvawnow.org/en/articles/304-adopting-a-human-rights-based-approach.html.

[11] J. Foote, S. Carswell, G. Nicholas, D. Wood, A. Winstanley and M. Hepi, "Selecting interventions to reduce family violence and child abuse in New Zealand: A report to The Glenn Inquiry.," Institute of Environmental Science and Research, Canterbury, 2013.

[12] K. Arroyo, B. Lundahl, R. Butters and M. Vinderloo, "Short-term interventions for survivors of intimate partner violence.," *Trauma Violence & Abuse,* vol. 18, no. 2, 2015.

[13] A. Cort, C. Cerulli, E. Poleshuck, K. Bellenger, Y. Xia, X. Tu, C. Mazzota and N. Talbot, "Interpersonal psychotherapy for depressed women with histories of intimate partner violence.," *Psychological Trauma: Theory, Research, Practice, and Policy,* vol. 6, no. 6, pp. 700-707, 2014.

[14] S. Talboys, "Victims of intimate partner violence: Evidence brief," New Zealand Government Ministry of Justice, 2017.

[15] E. Ogbe, S. Harmon, R. Van den Bergh and O. Degomme, "A systematic review of intimate partner violence interventions focused on improving social support and mental health outcomes of survivors.," *PLoS ONE,* vol. 15, no. 6, 2020.

[16] M. Basheer, R. Bekk and A. Boyle, "Systematic review of the effectiveness of advocacy interventions for adult victimes of domestic violence within an emergency department setting.," *Cureus,* vol. 14, no. 6, p. e25599, 2022.

[17] C. Warshaw, C. Sullivan and E. Rivera, "A systematic review of trauma-focused interventions for domestic violence survivors," National Center on Domestic Violence, Trauma & Mental Health, 2013.