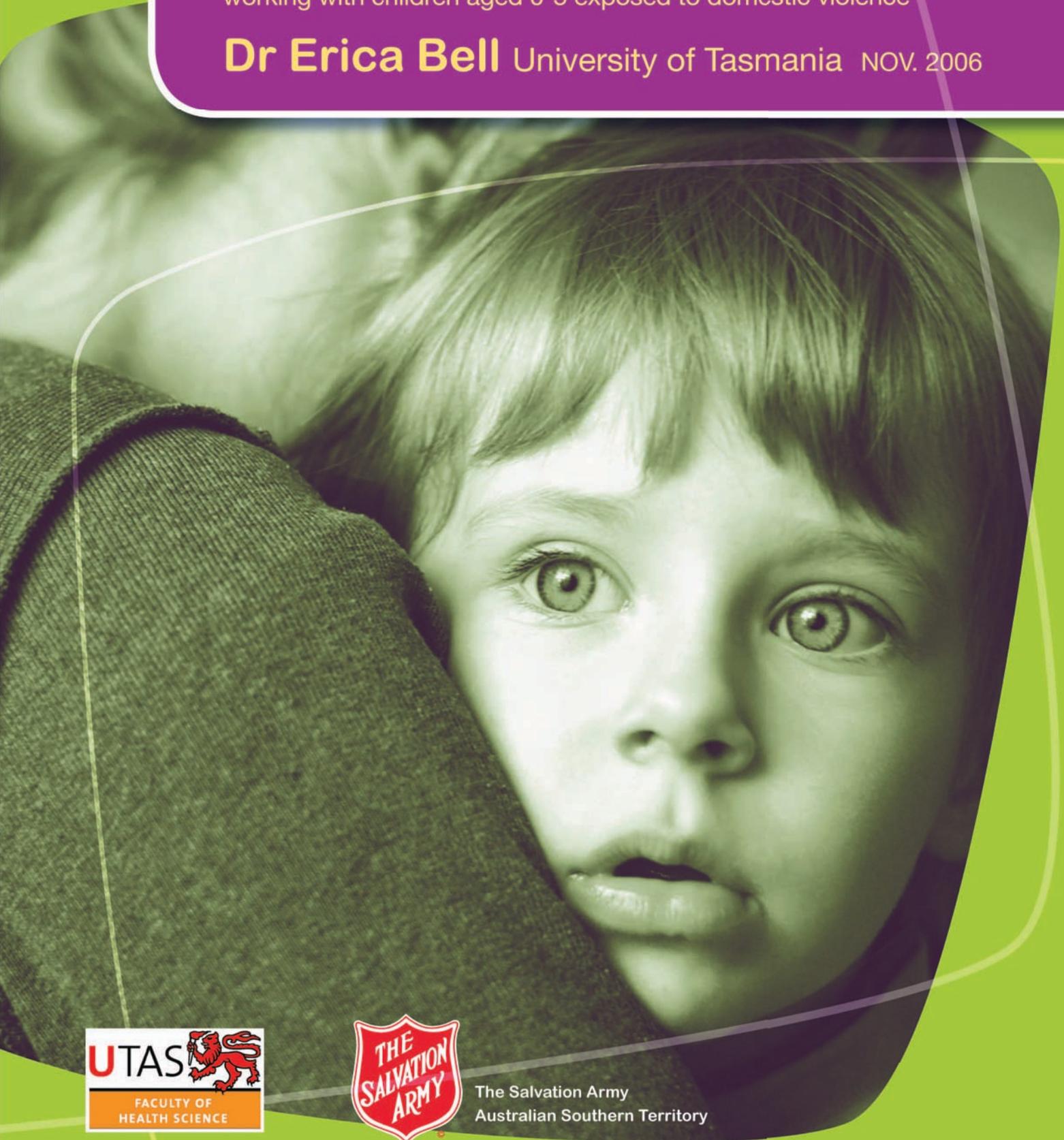


STATES OF MIND

A best practice framework for Women's Immediate
Emergency Accommodation SAAP Services in Tasmania
working with children aged 0-5 exposed to domestic violence

Dr Erica Bell University of Tasmania NOV. 2006



The Salvation Army
Australian Southern Territory

**‘States of mind’: A best practice framework for
Women’s Immediate Emergency Accommodation
SAAP services in Tasmania working with children
aged 0-5 exposed to domestic violence**

(Dr) Erica Bell



*A University Department of Rural Health consultancy commissioned by The
Salvation Army and funded by the Supported Accommodation Assistance Program
jointly funded by the State and Commonwealth Governments*

‘A best practice framework for Women’s Immediate Emergency Accommodation
SAAP services in Tasmania working with children aged 0-5 affected by domestic
violence’

ISBN 1 86295 280 9

Report 2007

Dr Erica Bell

University Department of Rural Health
University of Tasmania



Prepared and produced by the University Of Tasmania
University Department of Rural Health
Locked Bag 1372
Launceston TAS 7250

*This research has been approved by The Human Research Ethics Committee
(Tasmania)*

The material in this report is intended to be used as one of a number of resources for making decisions about policy and practice; it is not designed to be used as the sole basis for making those decisions; all such decisions should be scrutinised by legal professionals and other relevant experts in the field of crisis accommodation and domestic violence, including staff drawn from the office of the Commissioner for Children.

I want to talk with you about the “unthinking, non-reflective space” that accompanies violence in the home and the profound impacts on a child of a parent’s state of mind in its own right [...] an absence of child-focused thought can be perpetuated by the care-giving system and the legislation and policies that guide it. It is the overturning of such *unthinking states of mind*, in and out of the home, that so determines the nature of a child’s recovery from domestic violence.

— Jenn MacIntosh, Keynote address, National Forum on Children, Young people and Domestic Violence: The Way Forward 2000

Contents page

Executive summary and overview of recommendations.....	6
Project aims.....	9
Report structure.....	8
Method.....	8
Limitations of the project.....	11
The Tasmanian service context.....	11
Ethos and principles.....	17
Conceptual understandings of domestic violence.....	17
Defining the nature of the small child’s experience of domestic violence.....	17
Conceptualising the effects of small children’s exposure to domestic violence.....	21
Possible models for statements of service ethos and principles.....	26
Statements of ethos and principles already guiding Tasmanian SAAP services.....	27
A suggested ethos statement and set of principles for guiding the work of Tasmanian SAAP services as it relates to the needs of children (0-5) exposed to domestic violence.....	30
Assessment.....	30
Key issues.....	30
Models of best practice.....	33
Research evidence for particular tools.....	34
Assessment tools already in use by Tasmanian SAAP services.....	37
Suggested tools that may be useful to SAAP contexts.....	39
Key supports and links to other children’s services.....	40
Key issues.....	40
Models of best practice.....	42
Key supports and links already in use by Tasmanian SAAP services.....	46
Practical suggestions for improving key support and links to other children’s services relevant to SAAP agencies.....	48
Interventions, including key activities and therapeutic play modules.....	48
Key issues.....	48
Models of best practice.....	52
Evidence for particular interventions, including key activities and therapeutic play modules.....	56
Current interventions, including key activities and therapeutic play modules currently in use by Tasmanian Women's IEA SAAP services.....	59
Suggestions for interventions for Tasmanian contexts.....	60
Recording and reporting.....	60
Data collection issues in the literature and in SAAP services.....	60
Recommendations for developing the usefulness of data collection efforts.....	64
Staffing.....	64
Staffing issues in the literature and in SAAP services.....	64
Recommendations for developing SAAP staffing.....	67
Prevention.....	67
Prevention issues in the literature and in SAAP services.....	67
Recommendations for developing prevention activities.....	69
Conclusions: key areas for development of SAAP services towards this framework.....	69
References.....	72

Executive summary and overview of recommendations

The project aims to consider the specific needs of children aged 0-5 affected by family violence in Tasmanian Women's Immediate Emergency Accommodation (IEA) services. Specifically, it aims to identify key elements of a best practice framework for working with children aged 0-5; identify Assessment Tools for effective responses to children aged 0-5; identify key support and links to other children's services; identify key activities and therapeutic play modules for use by Family Support Workers and Child Support Workers in Women's IEA SAAP services; describe key current early intervention activities within Women's IEA SAAP services, and identify key areas where development of services could occur.

This study uses a select literature review, as well as the results of formal interviews with the managers of Women's IEA SAAP accommodation services, to develop key directions for moving policy and practices forward.

The study offers a suggested ethos statement and set of principles for guiding the work of Tasmanian IEA Women's SAAP services as it relates to the needs of children (0-5) exposed to domestic violence. The suggested ethos statement could include some elements from other models, though the advice given by IEA Women's SAAP agencies about their ethos matches and goes beyond many other statements, as follows.

- The child is a client in its own right and services should take a client-centred approach to meeting the child's needs: this approach should be individualised, culturally appropriate, non-judgmental, based on sound theoretical understandings of domestic violence, and delivered by qualified and well-equipped staff;
- The needs of the child are multi-faceted and therefore require a holistic approach involving networks with diverse community agencies and professionals;
- The safety and well-being of the child and mother is the first priority;
- The service should, where possible, support the authority of the mother and the positive development of the family unit, as part of family-based approaches;
- Children and their families should be treated with respect, dignity, and with a belief in their hopeful futures and their capacities to be empowered to build those futures;
- Effective interventions involve attention to both the child and the parent, separately and together;
- The service should create a supportive and safe environment with a non-blaming ethos;
- The service has a role in educating not only the child and family, but also the wider community.

The study also offers a list of suggested assessment tools useful to SAAP services and related electronic links for practitioners. It also provides directions for improving key support and links to other children's services relevant to Women's IEA SAAP agencies. The researcher's recommendations in this area, bearing in mind the literature on best practice and the issues raised by Women's IEA Tasmanian SAAP services, are as follows:

R1. That SAAP agencies have regular community network meetings with other relevant agencies to develop improvements in co-ordinated responses to the needs of small children, such as timely referral responses, on site visits, development of programs tailor-made for small children, and professional training in the functions of collaborating agencies; that this collaboration place special emphasis on including education services to help design better access to pre-schools in particular

R2. That a register of agencies be developed for referral of small children and their mothers exposed to domestic violence, including agencies offering on site visits

R3. That this report be referred to relevant Government offices, including the Department of Health and Human Services, for consideration of how to address the problem of the general overburdened nature of critical human services that are best positioned to meet the needs of small children exposed to domestic violence.

The study offers directions for interventions, including key activities and therapeutic play modules. These are as follows:

R4. That a register of interventions suitable for children aged 0-4 years and the evidence for them be set up by a peak body in the field of domestic violence

R5. That, in designing suites of activities for those children who need them, Women's IEA staff be informed by leaders in this field documented in this report such as the work of Leslie Givers (www.ggj.biz) and interventions listed by The Australian Domestic and Family Violence Clearinghouse (www.austdvclearinghouse.unsw.edu.au)

R6. That Women's IEA staff explore the value of age-appropriate group approaches used with appropriate professional support such as those of Peled, particularly for children at the top end of the age range that is the focus of this study i.e. children 3—5.

R7. That Women's IEA staff explore motivational interviewing techniques, implemented with appropriate professional support for its adult clients, particularly pregnant women exposed to domestic violence.

R8. That specific funding arrangements be made for the development of play centres at Women's IEA, including their ongoing maintenance.

R9. That the present study be used as a point of departure for a high quality empirical study of the effectiveness of commonly used tools for small children exposed to domestic violence, suitable for crisis accommodation service contexts; that this study utilise innovative social science methods that are able to deal with multi-dimensional client/service factors.

Some consideration is also given to other issues to do with data collection, prevention, and staffing issues, as well as other key areas for development of these services, with recommendations as follows.

R10. That data collection analysis of SAAP data include innovative quali-quantitative methods which have particular usefulness for service practitioners such as those developed by Charles Ragin and documented in this report.

R11. That the community agency network referred to in Recommendation 1 of this report also target optimal data collection and data sharing procedures between agencies, subject to legal and ethical requirements.

R12. That all staff in Women's IEA SAAP services who work with children exposed to domestic violence receive ongoing training through such bodies as the Partnerships Against Domestic Violence Program interstate, which can be contacted through the Office for Women. (http://ofw.facs.gov.au/womens_safety_agenda/index.htm)

R13. That each Women's IEA SAAP service that deals with small children who may have been exposed to domestic violence receives dedicated funding for a child support worker.

R14. That the community agency network referred to in Recommendation 1 of this report take a strong community education and prevention focus, expressed in a collaborative statewide plan, particularly through the involvement of pre-school and other early education specialists

R15. That Women's IEA SAAP services receive dedicated funding for community education and prevention activities

R16. That the limitation of six weeks be reviewed in a manner that is consistent with examining the issues of quality service delivery documented in this report.

R17. That the community agency network referred in Recommendation 1 of this report develop strategies for ensuring that critical high priority needs of Women's IEA SAAP clients are met in a timely fashion, including as they relate to small children.

R 18. That the community agency network's plan for statewide collaborative training for all Tasmanian services, referred to in Recommendation 11 of this report, include particular attention to training in legal issues and legal advocacy on behalf of community agencies to ensure their views are represented to government in the development of future legislation; that this work pay particular attention to the development of legislation that best positions services to respond to the needs of small children exposed to domestic violence.

Project aims

This research considers the specific needs of children aged 0-5 affected by family violence in Tasmanian Women's Immediate Emergency Accommodation (IEA) services. Specifically, it aims to

- identify key elements of a best practice framework for working with children aged 0-5
- identify Assessment Tools for effective responses to children aged 0-5; provide advice about any necessary amendments to these to make them suitable for Tasmanian contexts
- identify key support and links to other children's services
- identify key activities and therapeutic play modules for use by Family Support Workers and Child Support Workers in Women's IEA SAAP services; provide advice about any necessary amendments to these to make them suitable for Tasmanian contexts.
- describe key current early intervention activities within Women's IEA SAAP services, and identify key areas where development of services could occur.

Report structure

This report repeats a particular kind of structure designed to lead systematically to conclusions about directions for developing best practice. As suggested by the contents page, each sub-section in the three key areas of assessment, inter-agency collaboration (or key links and supports), as well as interventions, is structured to:

- examine the literature to explore key issues in a particular area of service delivery
- explore models of best practice
- examine the evidence for particular tools or best practices
- provide details of practices in Women's IEA SAAP services (from interviews with Women's IEA SAAP service staff)
- offer some conclusions about directions for developing Women's IEA SAAP services based on the above.

In the other sections, such as those on SAAP data collection, and staffing issues, and prevention, the discussion is largely restricted to available information from Women's IEA SAAP services, with some supplementary information from the literature.

Method

As indicated by the last section on the report structure, this study uses a select literature review, as well as the results of formal interviews with the managers of Women's IEA SAAP accommodation services, to develop key directions for moving policy and practices forward. The research brief relating to children from the ages of 0-5 has been interpreted as including women who are pregnant, so accordingly the needs of this group and the unborn child are included in the analysis of literature and SAAP practices.

In relation to the literature review the method has been selective, broadly inclusive but not all-inclusive, in the following ways.

In relation to the selectiveness of the study, the choice of material has been influenced by the fact that the best practice being talked about must be relevant to crisis accommodation services. If this report were to be a framework of how to deal with each and every need of small children exposed to domestic violence, it would be a very long report indeed. The study focuses very purposely on literature about domestic violence and small children as it relates to the specific research questions. This means, for example, that this report does not explore the broader literature on child development and the broad nature of interventions not specifically linked to domestic violence exposure, though that literature should not be neglected in a larger study. There has been explosion of literature in this area—to have included this other literature, for example, on learning difficulties which, as noted by a NSW enquiry into service provision for the early years (Standing Committee on Social Issues 2002), are shared by many children who have been exposed to domestic violence as well as those who have not, would have made this report too lengthy.

Accordingly, this report does not aim to, nor can it, explore particular special issues beyond the already complex questions in the research brief, such as issues to do with domestic violence for any particular cultural group in Australian society, or special issues to do with child sexual abuse or other specialised areas of the domestic violence literature. Such special issues have already been exhaustively documented in many resources, including Australian studies that examine the needs of such groups as rural communities, families from non-English-speaking-backgrounds, gay and lesbian couples, and aboriginal communities (Bagshaw et al. 2000). Nor does this study attempt to comprehensively answer a myriad of possible other questions about domestic violence to do with for example, the status and nature of data about its prevalence, or even the exact numbers of children in Tasmanian Women's IEA SAAP services (a recent study of service provision in Tasmania gives a figure that varies from 100% to 12% for clients presenting with dependant children to different Tasmanian services with crisis accommodation services towards the top end of those figures (Love 2003)). Figures provided by the Department of Health and Human Services reveal that in 2004-05, a total of 544 women and 850 accompanying children were accommodated at the six accommodation services providing Women's IEA in Tasmania. A further 2336 children received support services in the wider SAAP service system during 2004-05 (NDCA Curf data 2004-05). The text that follows focuses upon, and is structured by, the specific questions in the research brief.

In relation to the broad inclusiveness of this study, it should be noted that the literature on domestic violence covers many different kinds of settings. Many important insights and evidence generalizable to Women's IEA settings would have been missed if the researcher had chosen to concentrate only on research targeting Women's IEA settings. However, wherever necessary when citing best practice advice, the researcher has noted the original context in which that advice was designed. Clearly, there is a difference between best practice in screening in health care settings and Women's IEA settings, though the latter can benefit from knowing about research findings for the former.

Also on the subject of the inclusiveness of this review, this report has included many recent reports however, older studies that add value to understandings have not been neglected. That is, the presence of ‘out-of-date’ references in this study helps ensure that the findings draw upon the larger body of research, not simply recent work. As noted by one leader in this field (Jaffe et al. 1990)

In our work with children of battered women, we have been wary of not “reinventing the wheel” with new intervention programs when many existing treatment strategies could be applied to this population. (pp. 91-92)

In relation to the interviews that form the second kind of evidence used in this study, these involved six managers and staff in five of the six Women’s IEA SAAP services providing crisis accommodation to women and children in Tasmania. For ethical reasons, the anonymity of these SAAP services is protected in this report. Interviewers asked SAAP managers about their thoughts on best practice for Women’s IEA services responding to the needs of small children (0-5) who have been exposed to domestic violence. The interviews took the form of forty minute informal semi-structured discussions that used the following questions as a point of departure:

- 1) What are your thoughts about best practice ethos and principles (i.e. service culture and beliefs) for crisis accommodation services dealing with very young children 0-5 who have been exposed to domestic violence?
- 2) What do you see as best practice assessment of these children’s needs? What specific assessment tools do you use/think services should use?
- 3) What advice can you give about best practice in making referrals/using the support of other agencies? How do these links and supports work for your agency?
- 4) What about best practice in intervention, including key activities and therapeutic play modules...what interventions, including key activities and therapeutic play modules does your service use? Why? What in your view works best for these young children?
- 5) What do you see as the key issues in developing best practice in recording and reporting data in this area of client need? What recording and reporting does your agency do in relation to such clients?
- 6) What staff (broad experience and qualifications) are needed for responding to the needs of children exposed to domestic violence? What are the issues of best practice in staffing crisis accommodation services so that the needs of these children are better met?
- 7) Looking at the big picture, what do you see as the key directions for developing Tasmanian crisis accommodation services so they better meet the needs of children 0-5 exposed to domestic violence?

Findings from the interviews were integrated into the report in sections dealing with Women's IEA SAAP practices. These sections were reviewed by Women's IEA SAAP managers and staff in a group meeting, in a manner consistent with hermeneutic approaches to interpretation of interview data, which emphasise successive iterations involving research subjects as part of the hermeneutic 'circle'. Hermeneutic approaches have been popular in some health service research contexts aimed at arriving at a holistic understanding of the client's service experience and 'life world' or total experience (Allen 1995, Angus et al. 2005, Clarke 1999, Daniel 1986, Ekman and Skott 2004, Hick 1999, Lowes and Prowse 2001). They were particularly useful as a framework for developing an approach that was about participative styles of drafting interview analyses.

Limitations of the project

The project was completed for the sum of \$10,000, which under current University of Tasmania consultancy rates, equates to ten days of the researcher's time. Accordingly, the researcher limited the surveys of service staff to a small number of Women's IEA services (six invitations with five accepting), placing considerable emphasis upon obtaining answers to the complex questions in the research brief from scans of the research literature. This was designed to ensure that, on the one hand, the project avoided duplication, and on the other, that the researcher was sufficiently guided by service practitioner participation to target the literature appropriately for Tasmanian Women's IEA SAAP services.

The project has been able to identify elements of best practice and the tools either most commonly used and/or validated in the research literature. It has been able to recommend steps that Women's IEA SAAP staff can take to develop their practices in line with the literature and the evidence of what is already occurring in Tasmanian Women's IEA SAAP services. However, in a project of this length, it is not possible to undertake a trial of sufficient size and technical robustness to support statements about the detail of what amendments need to be made to make particular tools more or less useful than other tools. To have confidence in such statements, given the nature and complexity of interventions for small children in this situation, a much larger study is required bringing careful validation and measurement techniques. The organisations currently producing such information would also need to give their consent for the use of their tools, including in amended form.

Accordingly, recommendation 9 of this study suggests that a large-scale empirical study be conducted to high academic standards. Ideally this would involve a national and international survey of the views of staff of crisis accommodation services about best practice in this area that builds upon the work in this study, and includes a well-developed empirical trial of specific resources used in interventions in different crisis accommodation settings.

The Tasmanian service context

The State's SAAP services system, the Integrated Continuum of Support, was established in 2001 during SAAP IV. This system is based on an understanding that homelessness is not caused merely by lack of shelter, but involves a variety of underlying needs including physical, economic and social needs.

The range of services provided includes:

- preventative services;
- early intervention services;
- information and referral services;
- crisis services; and
- support services including skill development.

The range of services provided through each operational type is as follows:

Operational Type	Services are expected to provide:
Case Planning and Support	<ul style="list-style-type: none"> • early intervention; • crisis assessment and support; • information and referral; • access to non shelter based emergency accommodation; • long term case planning and support; • transitional support; and • access to sustainable long term accommodation.
Immediate Emergency Accommodation	<ul style="list-style-type: none"> • crisis assessment and support; • information and referral; • management of emergency beds; • shelter based emergency accommodation • long term case planning and support; and • transitional support.
Supervised Supported Accommodation for Young People	<ul style="list-style-type: none"> • provision of high-need supervised accommodation for young people; • long term case planning and support; • some crisis assessment and crisis support; and • information and referral.
Transitional Support	<ul style="list-style-type: none"> • long term case planning and support; • transitional support; and • access to sustainable long term accommodation.
Adolescent Community Placements	<ul style="list-style-type: none"> • crisis assessment and support; • information and referral; • long term case planning and support; • transitional support; • access to sustainable long term accommodation; and • supported supervised accommodation for young people with complex needs.

Restructure of the SAAP Service 2001

Through the restructure the Tasmanian Government, in partnership with the community providers, improved the outcomes for homeless people:

- through an increased emphasis on early intervention;
- increased diversity and flexibility of assistance available;

- develop more effective pathways to stable accommodation through better linked services; and
- enhanced management and administration arrangements.

The changed distribution of services achieved:

- An increased emphasis on Assessment and Support functions including Early Intervention;
- An increase in the range of emergency accommodation available with a decrease in the provision of shelter based crisis emergency accommodation;
- An increased capacity to provide support for clients independent of shelter based crisis accommodation; and
- A strengthened capacity for support to follow the clients through range of accommodation options.

Tasmanian service development for small children in Supported Accommodation Assistance Program (SAAP) services occurred in the context of broader social policies such as ‘Our Kids’, the 2002 Labor Party’s election campaign plank, which was adopted by the Department of Health and Human Services and offered an action plan for integrated responses to early intervention and service delivery (Department of Health and Human Services 2003).

Tasmania now has a whole of government policy framework for the early years—children 0-5 years, including the pre-natal period—that was endorsed by Cabinet on September 7, 2005 (Jenkins 2005a). It reflects the belief, also in federal initiatives emphasising early childhood, and supported by research literature, that the maximum gain will be from interventions in early childhood. It notes the steadily rising rates of child abuse and neglect in Tasmania, in the context of deepening social problems, the importance of responding to the particular needs of groups that include children exposed to domestic violence, and the difficulties services have had responding collaboratively to such holistic needs. While Jenkins’ report does not provide any information on the therapeutic value of specialised interventions targeting small children exposed to domestic violence, or related specific issues of service development, it is of particular value because it lists the main services and initiatives in Tasmania that support children under five and their families. The accompanying literature review is more valuable in this respect because it offers detail on the actual nature of these services (Jenkins 2005b).

Understanding the service contexts in which Women’s IEA SAAP facilities operate involves an appreciation of the roles of:

- the Department of Health and Human Services (DHHS) which fund Tasmanian Women’s IEA's and also deliver a number of services which directly impact on the health and well-being of women and children including, maternity care, healthcare, child protection, and mental health (involving the Child and Mental Health Service—CAMHS); recently reviewed, CAMHS faces particular pressures of high demand, suggested also by this report as well as a recent review of service provision in Tasmania for children (Love 2003).

The Family Child Youth Health Service (FCYHS) which offers universal health services for children under five, including child health nursing services, parenting support services, community child health centres, child development units, and outreach services to neighbourhood houses. DHHS' Children and Families also delivers Specialist Trauma Counselling services through its Family Violence Counselling and Support Service;

- the Our Kids Bureau (until recently part of DHHS' Children and Families Division) was set up to develop and manage policy and programs as they relate to children under 12 years; this bureau has taken a wide strategic leadership role; of particular interest is the professional development program which offers models of practice for identifying and intervening in the event of family dysfunction such as domestic violence, as well as child abuse and neglect;
- the Hospital and Ambulance Service across inpatient and outpatient services;
- community-based services, often funded by DHHS, offering neighbourhood houses, family support services (for example, those run by Good Beginnings, a national organisation, which include programs for ante-natal fathers; or other programs run by Centacare which involve specialist domestic violence services including a men's program), counselling, including domestic violence counselling, and sexual assault services, among others;
- general practitioners (GPs) in women's and children's healthcare;
- the Department of Education, for example, in programs like 'Strong Start' which aims to support families with small children (<4) in the Derwent Valley and West Tamar region, particularly in relation to learning and developmental disorders; other relevant programs include 'Early Learning Tasmania', and Early Years initiatives for migrant and refugee students;
- libraries, particularly in relation to the initiative 'Babies who read succeed';
- child-care services regulated by the Tasmanian Department of Education which total 308 across Tasmania;
- non-government schools which, for example in the catholic education sector, run kindergartens, and offer pre- and post-school care as well as vacation care;
- the Department of Police and Public Safety, particularly in community partnership initiatives using early identification and intervention principles across Tasmania; there are other relevant initiatives such as Police and Citizens Youth Clubs which include young parents;
- the Department of Justice and Industrial Relations, particularly in relation to recent legislative changes (the Family Violence Bill 2004) now requiring mandatory reporting by the police to Child and Family Services of cases of family violence involving children;

- the Whole of Government Safe at Home initiative, a proactive Family Violence Response, jointly funded by Police and Public Safety, Justice and DHHS.
- the Department of Premier and Cabinet, for example initiatives such as the Social Projects Units, Kids in Mind Tasmania, which aims to support families with small children and a parent with a mental illness, as well as other programs such as the Parent Assist program in Burnie and Devonport that is delivered by Anglicare;
- the Commissioner for Children responsible to the Parliament of Tasmania which has a broad policy development and watchdog role;
- the Tasmanian Community Fund which funds a range of initiatives using criteria focussing on support for children under three; and
- local government particularly in community development relevant to small children, though this area is not so well-developed in all councils (Jenkins 2005b).

The Jenkins' review concluded that many such Tasmanian services are fragmented and not well-integrated with others, have a limited funded life, are not supported by good population-based information and outcomes data, as well as good information sharing between agencies, and tend to focus on child protection rather than early intervention and prevention (Jenkins 2005b). This echoes studies from other states such as Western Australia, where a major study (Blanchard 1993) 'identified the lack of services for child victims of domestic violence which specifically relate to their needs and which can respond with immediacy and effectiveness' (p. 35-36).

A recent national review of children in SAAP services (Norris et al. 2005) provides other useful information about service contexts for the present study. It notes that SAAP services operate under the *Supported Accommodation Assistance Program Act (1994)* to provide transitional support and services to help homeless people achieve optimal self-reliance. This report emphasises that children should be recognised 'as people with service needs of their own, distinct from those of their parents and grandparents' (p. xiv). Following SAAP data collection approaches, it makes a key conceptual distinction between accompanying and unaccompanied children presenting to SAAP services, with smaller children in the first category. The report documents recent SAAP research and policy development initiatives targeting children, however, it notes that historically SAAP services were not designed with the needs of children as a priority, and this lack of emphasis has been noted in a number of studies and other reports. The Norris report notes the importance of interventions targeting the needs of children exposed to domestic violence, and the need to establish the necessary supports for these interventions, as well as ways of overcoming obstacles to these supports in SAAP services. Of particular interest for the present study is the emphasis on the need to develop SAAP services towards the following, as flagged in previous evaluations of SAAP services:

- a child-centred approach with child support teams integrated with more generalist teams
- child-oriented recruitment/training
- clear safety rules and protocols for all residents
- high quality assessment
- a separate well-equipped play area for children
- a service commitment to continuous service development (Norris et al. 2005).

It may be that services need to develop specialised approaches targeting particular client groups. The Norris report (Norris et al. 2005) also notes that children in agencies that target women escaping domestic violence ‘were likely to have low unmet need. For accompanying children this is encouraging, given the large proportion of cases this represents’ though ‘children attending agencies which targeted multiple client groups appeared more likely to have unmet needs’ (p.xiv).

Tasmanian SAAP services operate also within specific legislation. Of particular note in the present study is the Tasmanian Government’s Safe at Home strategy which was developed to address family violence, leading to a new law, the *Family Violence Act (2004)*. The Act came into affect in March 2005. This act provides for a range of new powers that will shape the future service contexts of SAAP services. For example, police can issue Family Violence Orders on the spot, which can last for 12 months, and there are expanded case management roles for police. It is important also for service providers to be aware that economic and emotional forms of violence are defined in the act but not yet tested (University of New South Wales 2005).

Family Violence in Tasmania is defined by the *Relationships Act (2003)* as violence between family members most associated with a power/control motivation. In addition to physical assault, including sexual assault, the definition of violence includes threats, coercion, intimidation or verbal abuse, abduction, stalking and economic abuse.

In May 2004 the Tasmanian Government launched Safe at Home, a package of initiatives to reduce the incidence of family violence in Tasmania. The initiative is a pro-arrest, pro-prosecution response to family violence which integrates and expands the range of service available to assist adults and child victims of family violence.

As part of these new and expanded services the Family Violence Counselling and Support Service was established. The FVCS Service provides a specialist service for the counselling and support of adults and children as well as information and advice on Family Violence to victims and their families, those close to them and other professionals.

In addition, the mandatory reporting requirement included in the *Family Violence Act (2004)* requires by law that all children at the scene of a family violence incident must be reported to Child Protection and referred to the Trauma Counselling Service for assessment.

Ethos and principles

Domestic violence research is poorly theorised, though conceptual understandings of it are crucial to knowing what variables should be examined in any study (Fantuzzo and Mohr 1999). Accordingly, this section explores the literature on the nature and effects of domestic violence on small children, in ways that help frame conceptual understandings or thinking about small children's exposure to domestic violence. It does so in ways that are aimed at establishing a focus on the child in service development, in line with the arguments of a keynote speaker at a national Australian conference on domestic violence and children and young people (McIntosh 2000), cited at the front of this report:

I want to talk with you about the "unthinking, non-reflective space" that accompanies violence in the home and the profound impacts on a child of a parent's state of mind in it's own right [...] an absence of child focused thought can be perpetuated by the care-giving system and the legislation and policies that guide it. It is the overturning of such unthinking states of mind, in and out of the home, that so determines the nature of a child's recovery from domestic violence. (p1)

Conceptual understandings of domestic violence

Defining the nature of the small child's experience of domestic violence

'Family violence', or synonymously 'domestic violence' (the latter term is preferred in this study because it refers to the broader domestic situation), are terms that include a range of common abuses between family members, mostly but not always adult men against women intimates: not just physical violence, intimidation and threatening behaviours, but also emotional, sexual and financial abuses (Peckover 2003).

Investigations and service approaches that fail to understand the full picture of abuse may continue to fail to deliver. This full picture includes not simply 'atrocious stories' of physical violence, though even here there are a complex range of violent behaviours with different causes, dynamics, development patterns, and consequences, suggesting the importance of not generalising across different kinds of violence (Johnson and Ferraro 2000, Hegarty et al. 2000). Other tactics such as 'acts of degradation, enforced isolation, belittling, threats through the children, sleep deprivation, economic abuse, enforced pregnancy, sexual assault, enforcing trivial demands, threats of deportation and kidnapping for Asian women' have been described in accounts of family violence (Humphreys 1999). Australian definitions of domestic violence such as those published by the Australian medical Association and the Australian Public Health Association recognise the complex array of physical, verbal, economic, and social abuses involved in the term (Hegarty et al. 2000).

The place of children in relation to these behaviours has been described more recently in terms of 'exposure', a term that includes many different kinds of experiences of the violence, direct and indirect.

As suggested by the methods section, understanding the exposure of children 0-5 to domestic violence in this study involves understanding domestic violence and pregnancy. Research shows that the experience of domestic violence begins in-utero. Domestic violence can be directed at the unborn child, or it can take the form of 'business as usual' (Taft 2002). Australian and overseas evidence suggests that between four to eight or nine out of a hundred pregnant women 'are abused during their pregnancy and/or after the birth' and that women who have experienced abuse 'are less likely to have planned the pregnancy or to want it' (Taft 2002). One study suggests that pregnancy in the past year may be associated with an increased risk of current physical violence (Richardson et al. 2002) though there is disagreement in the literature that pregnancy is a time of increased risk for domestic violence (Shepard et al. 1999). Medical researchers rightly note that the apparent greater risk of domestic violence for pregnant as opposed to non-pregnant women is in fact a function of the increased risk of domestic violence for women of child-bearing age, and is not due to pregnancy alone (Mayer and Liebschutz 1998). What we do know is that pregnancy is an important opportunity for intervention: 'pregnancy may be one of the few times when chronically abused women are permitted to go to the doctor' (Taft 2002).

Early post-natal experiences of domestic violence also figure in the literature: the first six months after pregnancy have been identified as a time of particular risk for battering (Shepard et al. 1999). Such violence can be the result of jealousy directed at the infant and/or the male partner's negative feelings about fatherhood (McGee 2000).

Ex-utero, the small child's exposure to domestic violence can take different forms, from watching or hearing violent events, to trying to intervene, to witnessing the aftermath of bruises and maternal depression (Fantuzzo and Mohr 1999). As noted in one study, the different ways in which children can be involved in domestic violence is not well recognised in the research which 'tends to assume that exposure is a uniform experience' and often does not involve actually asking children themselves about their exposure (Wolfe et al. 2003). One valuable review of the effects of domestic violence on children (Carlson 2000) summarises what the child's exposure can mean and why it has been difficult to measure it:

There are several ways beyond being an eyewitness that children can be exposed to interparental violence. These include overhearing violent conflicts, becoming a target of violence or becoming a participant in the conflict by attempting to intervene in it, and observing the aftermath but not the conflict itself [...] for the most part, research has not examined the different types of exposure, relying almost exclusively on the victimized mother to report on the nature of her children's exposure [...] Parents may be unaware that children are nearby or think that they are asleep and thus not being affected. There may also be cognitive distortions involved in that parents may be reluctant to acknowledge that their children are being exposed to emotionally upsetting conflicts that they feel powerless to control or from which they believe they are shielding them. (p. 323)

The child witnessing or exposed to violence between its parents is much more likely also to be a target of not only parental violence and child abuse but also sibling violence (Kelly 2000, Humphreys 1999, Fantuzzo and Mohr 1999, Indermaur 2001, Moffitt and Caspi 1998, Edleson 1995).

Many studies ‘have found that substantial numbers of child witnesses are also victims of physical abuse by one or both parents’ (Carlson 2000) (p. 330), such that it can be concluded that the link between maternal domestic violence and child abuse is well documented (Parkinson et al. 2001, Edleson 1995). Yet as noted by at least one researcher (Edleson 1995), there is a need to define the *nature* of the link between domestic violence and child abuse, which can take obvious and not so obvious forms ranging from violence to neglect and psychological harm that itself arises from being a witness to violence:

...there is no consensus on whether a child who witnesses violence in his or her home is a victim of child abuse and neglect. Does witnessing violence involve “mental and emotional injury,” a reportable form of child abuse in the majority of U.S jurisdictions[...]? (p. 3)

A study (McGee 2000) of the accounts of children aged from five to late adolescence identified a number of elements of the domestic violence situation itself as part of an analysis of children’s experience of domestic violence. These include, but are not limited to:

- *‘trigger’ events* which can be random, everyday events, to do with partner jealousy, alcohol abuse and so on; for example, an adult male might irrationally quiz the child about the mother’s imagined infidelity, which might result in the child being subject to abuse
- *violence onset* which can involve long-term ‘gradual onset’ with this ‘build up’ often involving a range of behaviours that mothers may find difficult to recognise as domestic violence
- *controlling behaviours* which are part of the abuse both during and after the relationship, often involving the children; for example, children may be isolated from normal social contacts and support, and the abuser may even stop the mother from attending to the needs of the children and/or subject the children to unusual regimentation
- *emotional and psychological abuse* concurrently or after the onset of physical abuse, for example, using the children to belittle or humiliate the mother
- *physical violence* which, for example, can occur when the mother is actually holding the child, and can often be directed against the unborn child; it can include abuse of the child such as throwing the child when the child tries to intervene to protect the mother
- *sexual violence*, which can include rapes witnessed by the children, and threats (whether carried out or not) of sexual assault of the children
- *economic abuse* which can include depriving the children of food and clothes.

Clearly, the definitional issues involve recognising that not only different kinds of violence happen but also that they happen to different people. ‘Couple violence’ is a term used to describe situations where both male and female partners have been perpetrators and victims of domestic violence (Indermaur 2001). However, domestic violence does not always involve heterosexual males assaulting females in the context of traditional marriage.

Children are involved in other domestic situations that involve violence such as contexts where their parent is dating someone i.e. 'dating violence' linked to teenage pregnancy (Rosen 2004), or where their parents are cohabiting, or contexts where the adults involved are gay couples or lesbian couples, or contexts where the parent assaulting a partner is a heterosexual women physically assaulting a male (Cantos et al. 1994).

It is not simply that different kinds of violence happen to different people; it is also true that different community figures are actors in the domestic violence. In relation to policing, which often interrupts domestic violence (Hoyle 2000), it should be emphasised that the child's exposure to domestic violence can also include witnessing incidents between police and significant adult figures at particular stages of the violence, though domestic violence studies rarely explore the involvement of community agencies such as police in the domestic violence incident from the perspective of the child.

Notwithstanding these qualifications, domestic violence is still almost overwhelmingly (97% of cases is a common figure) represented in the literature as being about males perpetrating violence on women (Walby and Allen 2004), with resistance to this violence being primarily by women (Johnson and Ferraro 2000), and injuries, particularly severe injuries, being primarily experienced by women (Cantos et al. 1994). An Australian survey suggests a higher incidence of male to female parental violence exposure by children 12-20 living with 'mum and her partner'; it also suggests that young people with a lower socioeconomic background are more aware of violence to either parent, and that indigenous youth in the study were more exposed to domestic violence (Indermaur 2001). Australian public records such as police records, crime surveys and hospital figures suggest that male to female domestic violence is far more common than female to male, at least in relation to the kinds of heavy physical abuse that are extant in those records (Hegarty et al. 2000).

Significantly, few studies are available to describe the profiles of the perpetrators of domestic violence, most focus on its effects on the victims. However, one study (Romans et al. 2000) defines the abuser in the following terms, in ways that add to our understanding of the complex situation of the small child being exposed to the violence:

Men who commit domestic violence are more likely to be young, unemployed, and in casual or de facto relationships rather than legal marriages; they are likely to have witnessed violence as children in their own families; and they may have a range of psychiatric problems ranging from depression to substance misuse. Many perpetrators are violent under the influence of alcohol but a substantial proportion are violent even when sober. (p. 485)

Another researcher (McIntosh 2000) concludes:

Chronic domestic violence is typically characterised by a man whose own profound experience of childhood abuse has led him to dissociate or cut off unconsciously from his own fear, and the fear of others, including his children. This state of mind enables acts of extreme aggression in front of his own children, upon their mother, whose own history and current trauma have led her into a state of dissociation from aggression, that makes the cycle of fear and victimisation very hard to break. (p.4)

Understanding the small child's exposure to domestic violence also involves understanding the importance of time and timing. Domestic violence is not generally a 'one-off' (Warshaw 1998), and that is probably even truer for female victims: a recent large British study found that

Among women subject to domestic violence (non-sexual threats or force) in the last year, the average number of incidents was 20, while 28 per cent experienced one incident only. Of men subject to domestic violence (non sexual threats or force) in the last year, the (mean) average number of incidents was seven while once incident was experienced by 47 per cent. (Walby and Allen 2004)

In short, domestic violence is often about a systematic pattern of abusive behaviours (Schorstein 1997). As noted in a previously cited study (Carlson 2000), duration of violence is also important to understanding the effects of domestic violence on children:

Children who have been exposed over a long period of time are likely to react with more distress than children who have no such history. That is, most children apparently do not habituate to parental conflict, although some may become desensitised over time. Instead, a history of exposure appears to sensitise children to future conflict so that they are more upset by such conflict than children from non-violent homes...(p. 329)

The literature, including that on policing issues, notes that the violence can continue and even become more serious, after separation and divorce (Hoyle 2000).

Part of understanding domestic violence is about recognising it is a multi-dimensional situation shaped by a complex set of long recognised multiple risk factors and 'chronic adversities' such as homelessness, fractured attendance at preschool and school, maternal and child psychiatric morbidity, and poorer social supports (Vostanis et al. 1997, Vostanis et al. 1998). As noted, it can also be a feature of a specific situation, such as can occur in a high conflict divorce situation (Ayoub et al. 1999).

Development of services in the area of domestic violence also need to be shaped by understandings of different cultural traditions, immigrant status, lack of fluency in English, religious background, and so on, which create special needs to which best practice models of crisis accommodation must respond (Saathoff and Stoffel 1999). Some of the causal factors are quite complex. For example, at least one study of religious views and domestic violence suggests that 'men who hold much more conservative theological views than their partners are especially likely to perpetrate domestic violence' (Ellison et al. 1999).

Having explored the complex nature of the small child's exposure to domestic violence, as documented in the research, we will now turn to the question of how the research appears to conceptualise the effects of this violence on small children.

Conceptualising the effects of small children's exposure to domestic violence

The use of appropriate interventions for young children requires an understanding of the effects of family violence upon them. To that end, this section aims to outline some of those effects.

As noted by a social historian commenting about her experience of writing an extensive history of social responses to domestic violence in America, the causes and consequence of this violence are complex and multi-faceted and an understanding of them is not to be gained by offering up a single explanation based on historical or any other excavation:

From the beginning I decided against making large and difficult-to-prove claims against either the consequences or the causes of domestic violence[...]. If pressed now, I would refer to a variety of risk factors that can encourage family violence and a variety of protective factors that can subdue it or mute its negative effects on an individual. (p. xi.)

Yet the history of social responses to the effects of domestic violence is part of the story of service responses today. Society has recognised and campaigned against domestic violence since colonial times (Hafkin Pleck 2004), though in the USA and other western countries domestic violence rarely appeared in courts, and it was seen by the legal system as a private matter at least till the 1970s (Lemon 1999).

Yet while concern over women affected by family violence has figured in public discourses in the last three decades, and shelters for women affected by domestic violence grew in number in the 1970s (Flitcraft 1993, Saathoff and Stoffel 1999), the concern about children has been later and more uneven (Fantuzzo and Mohr 1999, Gelles 1985) though it is now a growing area of research (McAlister Groves 1999, Wolfe et al. 2003). However, and as noted in a review of the impact of domestic violence on children, while a considerable amount has been written about adolescents' experiences of domestic violence, and its effects on them, there is relatively little literature on the impact on younger children (Osofsky 1999). Studies that focus on accounts provided by children of domestic violence and its effects on them invariably focus on children ranging from 5 years into adolescence (McGee 2000).

It is worth beginning an exploration of the effects of domestic violence with some sense of how many small children are exposed to it. Australian data suggest that up to a quarter of young Australians (12 to 20) have been exposed to an 'incident of physical or domestic violence against their mother or stepmother' (Indermaur 2001). One USA based study (Carlson 2000) estimates conservatively that 'at least 10% to 20% of children are exposed to intimate partner violence yearly, with perhaps as many as one third exposed at some point during their childhood' (p. 323). Rates of violence in the USA at least are highest among women and men in their twenties, indicating the high risk of young children being exposed (Koenen et al. 2003). New Zealand research suggests that 'partner abuse is most common among the young parents of small children' and other studies confirm that 'young children and partner violence are concentrated together in the same population' (Moffitt and Caspi 1998). Given the present study's emphasis on children 0-5 affected by domestic violence, it is worth noting that an American study identified that 10% of women seeking treatment for their children in an urban paediatric emergency department with children less than 3 years old reported being in abusive relationships over the last year, 28% reported childhood sexual abuse, and 52% reported histories of adult physical abuse (Duffy et al. 1999).

A discussion of the effects of domestic violence on children 0-5 years should begin with the unborn child.

The literature documents the effects of domestic violence in pregnancy: such violence can have both dramatic and subtle effects on both maternal and foetal morbidity and mortality (Mayer and Liebschutz 1998). In pregnancy, the 'common consequences of abuse, such as stress, drug and alcohol abuse, smoking, eating disorders and/or injuries' work to damage maternal health, jeopardising birth outcomes and infant health (Taft 2002). As has been noted, some domestic violence can be targeted specifically against the unborn child, for example, in the form of physical violence directed at the woman's abdomen (Taft 2002). Domestic violence can also have subtle detrimental effects such as that caused by the perpetrator isolating women and causing them to miss their prenatal medical appointments. Such conceptual understandings of the nature of domestic violence allow us to understand it in terms of a larger complex situation in which, for example, there may be poor levels of self-care such as poor nutrition related to the domestic violence (Mayer and Liebschutz 1998).

In relation to the ex-utero child: for over a decade researchers (Blanchard 1993) have pointed to evidence that the assumption that very small children are unaffected by domestic violence is a mistaken one, noting that in fact 'The school-age child is likely to have more supports outside the family and so has greater capacity to weather the effects of family violence than the younger child' (p. 32). A draft framework for an Australian national agenda for early childhood (Commonwealth Task Force on Child Development Health and Wellbeing 2003) led by Professor Fiona Stanley notes

...how much the brain develops in a child's early years, including during pregnancy, setting a structural foundation for later development and life chances. Connections between the nerve cells of the brain are established and pruned by a process that is affected by environmental factors. There are sensitive periods for brain development, many of which occur before the age of six[...] early childhood presents a window of opportunity where intervention are likely to be more effective and influence a wider range of outcomes than interventions later in life. (p.3-4)

Accordingly, there are strong arguments in the literature (McIntosh 2000) that the effects of domestic violence begin at a very early age:

We are far too often lured into thinking that infants and even toddlers are too young to be affected by domestic violence. Research is rapidly proving us wrong. From two weeks of age, infants have been observed to make organised attempts to physically defend themselves when carers do not. Violence witnessed as young as two months old is held vividly in non-declarative memory, and if untreated can be expressed in fragmented form throughout the child's life. Emotionally, infants and toddlers who have witnessed or experienced prolonged family violence are highly likely to develop disorganised attachments to their mothers. This means that they develop no coherent strategy for obtaining comfort when it is needed and that they are frequently frightened by the presence of their mother, as well as by the presence of the perpetrator of the violence. (p. 11-12)

Another study (Hester et al. 2000) notes that pre-school children are more likely to have physical symptoms following exposure to domestic violence such as sleeping difficulties, bedwetting, stomach aches and asthma (Hester et al. 2000).

The high-conflict behaviours of parents are known to have powerful effects on an individual's adjustment in childhood, adolescence and adulthood.

The direct effects of such high-conflict behaviours relate to modelling of parental behaviour, failure to learn social skills, and physiological effects. Indirect effects relate to impaired parenting opportunities, such as less father involvement and/or negative interactions with the father (Kelly 2000). Violence itself, particularly combined with other risk factors such as child abuse, poverty and parental mental illness, has been shown in clinical and other research to be linked to pervasive effects on child development, ranging from mental health problems such as depression and anxiety, to lower levels of social competence, behavioural problems, and poorer academic and verbal functioning (Fantuzzo and Mohr 1999, Huth-Bocks et al. 2001, Wolfe et al. 2003, Feldman et al. 1995, Carlson 2000). In relation to cognitive functioning, studies refer to diminished Neuro-cognitive functioning from environmental factors that work to suppress IQ (Koenen et al. 2003) and delay development (Hester et al. 2000). The literature also indicates, with less confidence (Wolfe et al. 2003), that family violence is linked to post-traumatic stress disorder (PTSD), and co-morbidities across different mental health symptom classes, particularly phobias and separation anxiety (McCloskey and Walker 2000).

The research also documents long-term negative effects on life satisfaction, self-esteem, psychological distress, and violence in one's own relationships (Kelly 2000, Indermaur 2001, Purvin 2003)—though any simplistic notions of the inevitability of intergenerational transmission of the violence are not supported (Johnson and Ferraro 2000, Smith and Williams 1992). Powerful arguments for intervening in children's experience of domestic violence have been presented by at least one major Australian study pointing to the significance of intergenerational transmission of domestic violence—not its inevitability for all or even most children exposed to domestic violence (Indermaur 2001).

However, as noted by at least one researcher, the literature on the effects of domestic violence need to be interpreted with great caution—not used as the basis for broad-brush judgments about any individual child—not least because some studies do not distinguish between children who have witnessed abuse and those who were also abused (Edleson 1995).

The present study noted earlier that domestic violence needs to be understood in terms of time and timing. In relation to timing, the research suggests that exposure to domestic violence produces different problems of child development depending on the age of exposure (Fantuzzo and Mohr 1999). This raises the question 'If many different kinds of effects on children can be found in the research, what does this research say about typical patterns of these different effects at different ages?' A previously cited review of the literature (Carlson 2000) notes in relation to children that 'no single pattern of immediate or short-term effects to exposure to domestic violence has been found' (p. 322). However, this same study notes that 'externalising behaviour problems such as aggression, disobedience, non-compliance, hostility, and oppositional behaviour are the most commonly observed patterns of response' (p. 325). Significantly, the literature notes that some children may appear to emerge from exposure to domestic violence 'relatively unscathed' (McAlister Groves 1999, Carlson 2000). However, the work of some researchers (McGee 2000) makes it clear that children's emotional reactions to domestic violence are complex and intense and include feelings of fear, sadness, including self-harming reactions, anger, powerlessness, loss of self-identity.

Children affected by exposure to domestic violence may not exhibit obvious external signs. Accordingly, practitioners need to be careful about what it means to say a child is affected by exposure to domestic violence and what it means to say a child has suffered abuse and neglect. For example, given the severity and range of the effects of domestic violence, and the earlier point made about the link between domestic violence and child abuse, it is not surprising to find that at least one study argues that in some cases the effects of domestic violence on the child 'may be so serious as to constitute abuse' (Stanley 1997).

What we also do not know is the impact of 'particular types or frequencies of domestic violence on children, or how children with specific characteristics [including gender and ethnicity] are affected across time' (Fantuzzo and Mohr 1999). The Australian study referred to earlier involving 12-20 year olds identified gender differences such as girls being more likely to have been frightened by an episode of intimate aggression, and being more likely to have been sexually assaulted (Indermaur 2001). Another study notes the relationship between 'witnessing domestic violence as a female child and being abused in later relationships' (Purvin 2003).

What mediates the effects of domestic violence? One study concludes with reference to the research literature that;

...children's responses to the experience of seeing their father assault or threaten their mother will be mediated by a variety of different factors such as their age, their role in the family and the extent and frequency of the violence. Such factors will need to be taken into account in assessing whether the child is experiencing emotional abuse or is at risk of 'significant harm'. (Stanley 1997)

A review of the literature concluded that 'the most important resource protecting children from the negative effects of exposure to violence is a strong relationship with a competent, caring, positive adult, most often a parent' (Osofsky 1999, Ayoub et al. 1999) with some evidence this ameliorates trauma symptoms (Ayoub et al. 1999). Other research points to, for example, the possibility that close positive sibling relationships are known to have a powerful 'buffer' effect against high conflict parental relationships, though, as has been noted, sibling violence is also often part of the domestic violence situation (Kelly 2000, Humphreys 1999).

However, in relation to specific outcomes of domestic violence, there is research exploring a whole host of variables that might be thought to work as potential mediators of post-traumatic stress disorder experienced by child witnesses to domestic violence: age, gender, locus of control, self-blame, perception of threat, active versus palliative coping style, maternal emotional health as well as aspects of the violence itself such as intensity, frequency, and age of child when first witnessing violence. This research concludes that, while its findings should be interpreted with caution, there was evidence that these variables did not work to mediate PTSD in child witnesses, adding that 'evidence that variables specifically related to the violence witnessed did not mediate the impact suggests that all domestic violence may have severe and long-term impact on child witnesses' (Kilpatrick and Williams 1998) (p. 319).

The more persuasive studies of ameliorating factors in the effects of domestic violence on children are those that argue for an 'ecological perspective' in understanding those effects i.e. that the effects on women and children need to be understood in terms of the wider contexts in which the individual develops (Levendosky and Graham-Bermann 2001). For example, the effects of domestic violence are also felt by the child as the mother tries to move away from the violent situation, and can only be understood in terms of that total situation:

The break-up of relationships following domestic violence can bring new problems for children. Children may lose their home, their school and local friends and contacts. (Stanley 1997)

Clearly, the research is still developing understandings of the nature and operation of mediating factors. In the meantime it seems wise not to assume that the effects of domestic violence are mediated by factors the layperson might assume offer a protective mantle for the small child. Nor does the literature on the nature and effects of domestic violence provide a basis for making assumptions about the individual needs of children presenting to SAAP services, though it does raise a whole host of issues that might be relevant to that child.

Possible models for statements of service ethos and principles

The research literature, which documents the nature and effects of domestic violence on small children, is not so well developed when it comes to the kinds of service ethos and principles that follow from such research. Three models of statements of service ethos and principles have been selected for presentation in this section: one drawn from the Tasmania service context (itself based on a literature review), a second statement drawn from an Australian service guidelines, and a third statement drawn from an American service handbook.

The Tasmanian whole of government policy framework (Jenkins 2005a) draws upon a literature review identifying features of best practice to offer a set of broad principles for service delivery for small children and their families that emphasise:

- a sound theoretical framework for service delivery based on evidence
- qualified and well-equipped staff
- family-centred approaches
- individualised, responsive service delivery
- developing strong practitioner-family relationships
- providing sound information
- responsiveness to cultural and other client diversity
- sustainable coordinated community-based responses (p. 34).

These key elements of principles for best practice are also reflected in the key findings of service evaluations of relevant family support programs such as published guidelines for evaluations of service delivery for services working with children who have been exposed to domestic violence (Gevers 1999a). Echoes of them can also be variously found in formal evaluations of relevant programs such as parenting programs run by non government agencies (Department of Family and Community Services 2004).

An Australian text focusing on best practice in service delivery for children (Gevers 1999b) outlines definitions of mission and goals used by Queensland child support workers in crisis accommodation, which focus on:

- the right of children to live free of abuse
- the responsibility of the family and community to protect that right
- releasing children from any responsibility for the violence
- sharing with a safe environment created by the worker
- child-focused, non judgmental approaches
- valuing the child in a non discriminatory environment receptive to cultural and other diversity
- exploring experiences of domestic violence
- strengthening family relationships
- safety education for the child
- developing strong community links.

Given the volume of literature from America on domestic violence, it may be helpful to end this section with an example from this country. A particularly comprehensive American handbook published by the Family Violence Prevention Fund in San Francisco (Warshaw 1998) emphasises the following principles guiding clinical practice in this area:

1. Regarding safety of victims and their children as a priority
2. Respecting the integrity and authority of each battered woman over her own life choices
3. Holding perpetrators responsible for the abuse and for stopping it
4. Advocating on behalf of victims of domestic violence and their children
5. Acknowledging the need to make changes in the health care system to improve the health care response to domestic violence.

Statements of ethos and principles already guiding Tasmanian IEA Women's SAAP services

This section documents the accounts of service ethos and principles given by SAAP agency staff (managers and key workers).

IEA Women's SAAP agencies participating in this study advised they are using the following principles in their work with small children exposed to domestic violence:

- The child is a client in its own right and services should take a client-centered approach to meeting the child's needs;

- The needs of the child are multi-faceted and therefore require a holistic approach involving networks with diverse community agencies and professionals;
- The safety and well-being of the child and mother is the first priority;
- The service should, where possible, support the authority of the mother and the positive development of the family unit;
- Children and their families should be treated with respect, dignity, and with a belief in their hopeful futures and their capacities to be empowered to build those futures;
- Effective interventions involve attention to both the child and the parent, separately and together;
- The service should create a supportive and safe environment with a non blaming ethos;
- The service has a role in educating not only the child and family, but also the wider community.

SAAP Service Standards and the Integrated Continuum of Support principles

The following standards and principles govern the delivery of SAAP services in Tasmania and are form part of a Service's service agreement with the Department of Health and Human Services.

The SAAP Standards (April 1998) provide services, clients and administrators with concise guidelines on what can be expected from SAAP funded services. The standards clearly state that, for services working with children accompanying adults, children must be treated as clients in their own right as well as a part of their family unit, in order to ensure their individual needs are identified and met. Services must also work in accordance to the *Children, Young People and Their Families Act 1997*.

The Principles Overarching SAAP Service Delivery are:

1. Protection of human rights and freedom from abuse
2. Confidentiality, privacy and access to personal information
3. Client rights upheld
4. Client self-determination
5. Needs based service delivery
6. Non discriminatory access and support
7. Culturally appropriate service provision
8. Effective and efficient management
9. Safety and security
10. Responsiveness to all clients

Principles that guide the provision of SAAP services Integrated Continuum of Support (Department of Health and Human Services SAAP IV Module and Function Specification) are as follows:

Services tailored to achieve the best possible outcomes for clients

All clients are unique, their needs often being complex and diverse, requiring services developed specifically to meet these needs. Flexibility in service delivery is encouraged. Services will focus on, and be reviewed against, the results that are achieved for clients.

Improving Collaboration and Service Delivery Arrangements

Responsibility to respond to the needs of clients is often spread across a range of organisations and government departments. The services provided to clients should be seamless and aim to minimise the disruption to the client's life. Service arrangements will require collaboration in the planning and delivery of services at a regional and local level. Service arrangements will emphasise the complementary nature of services provided and maximise the opportunities for the development of a service continuum.

Early Intervention

Early intervention is defined in SAAP as the provision of support services to a person immediately before and at the point of homelessness. The disruption caused by homelessness can be minimised through the provision of timely support services. Increased support for families and individuals still accommodated and at risk of becoming homeless will be provided. Intervention will also be provided at the earliest possible point of crisis to minimise ongoing effects of homelessness.

Safety Net

Government ensures that those who are homeless have access to a safety net of services, including emergency shelter and other crisis support services. These services are funded from SAAP. The Australian Bureau of Statistics indicates that nationally only 14% of those who are homeless use shelter-based emergency accommodation. At the time it was estimated that 13% of those who were homeless in Tasmania were using shelter-based emergency accommodation¹. The continued development of new and improved ways of providing services will be an important feature of the Integrated Continuum of Support.

Integration in Local Communities

Housing opportunities and support should be integrated into the local community minimising disruption in people's lives, and enhancing participation in community activities, employment and education. Services will maximise client's choice, independence and self-reliance.

¹ Estimates derived from ABS national Census 2001 and published in Counting the Homeless 2001 (2050.0)

A suggested ethos statement and set of principles for guiding the work of Tasmanian IEA Women's SAAP services as it relates to the needs of children (0-5) exposed to domestic violence

The suggested ethos statement could include some elements from other models, as follows, though the advice given by IEA Women's SAAP agencies about their ethos matches and goes beyond many other statements:

- The child is a client in its own right and services should take a client-centred approach to meeting the child's needs: this approach should be individualised, culturally appropriate, non-judgmental, based on sound theoretical understandings of domestic violence, and delivered by qualified and well-equipped staff;
- The needs of the child are multi-faceted and therefore require a holistic approach involving networks with diverse community agencies and professionals;
- The safety and well-being of the child and mother is the first priority;
- The service should, where possible, support the authority of the mother and the positive development of the family unit, as part of family-based approaches;
- Children and their families should be treated with respect, dignity, and with a belief in their hopeful futures and their capacities to be empowered to build those futures;
- Effective interventions involve attention to both the child and the parent, separately and together;
- The service should create a supportive and safe environment with a non-blaming ethos;
- The service has a role in educating not only the child and family, but also the wider community.

Assessment

Key issues

This section draws on the literature to explore available knowledge about best practice in this area.

The literature does not always recognise the highly specialised nature of assessment in relation to small children's exposure to domestic violence (Dickens 2002). It suffers sometimes from definitional looseness. In fact 'screening' and 'identification' and 'assessment' and are all terms that have been used to mean the same, overlapping or quite different things.

However, it is worth keeping their differences in mind. ‘Screening’ is a scientific and biomedical term, and refers to a broad range of inquiry processes that happen in healthcare service contexts—such as ‘screening’ for general psychosocial problems, or specifically for domestic violence (Taft 2002). ‘Identification’ can be an outcome of effective screening and is associated with finding out if a child is being exposed to domestic violence. However, the term ‘assessment’ is often used to find out more about the situation and child’s needs, as a basis for making choices about appropriate intervention (McAlister Groves 1999).

There are also questions about the value of these three different things in different service contexts. For example, there is a big debate about ‘screening’ for domestic violence in healthcare settings which are faced with the reality that when women do disclose domestic violence they tend to do so to GPs (Taft 2002). In healthcare settings at least it has long been recognised that ‘it is likely that indirect observations alone are an insufficient means of screening’ (Parkinson et al. 2001). However, surveys of how acceptable women in primary healthcare find screening for domestic violence suggest that only between 43-85% find screening acceptable, and it has been argued that many practitioners also do not support it (Ramsay et al. 2002). This study argues that other than a modest increase found in identification and subsequent increased referral, there is little evidence that screening in healthcare settings at least actually results in positive outcomes such as decreased exposure to violence or at the very least does not cause harm to the women being screened (Ramsay et al. 2002). On the other hand, another study concludes that ‘concerns about lack of acceptance of maternal screening at paediatric visits seem to be unfounded. Screening may actually increase satisfaction with care’ (Parkinson et al. 2001). A further study found that many women do reveal domestic violence when screened in a paediatric healthcare setting (Siegel et al. 1999). An Australian study of clinical presentation issues argued that while opportunistic screening is indicated rather than screening of the whole population bearing in mind that ‘women who have experienced partner abuse want to be asked about it and are more likely to disclose if asked in an empathetic, non-judgemental way. Doctors can make a difference’ (Hegarty et al. 2000). A still relevant point is made by a now out-of-date USA paper on domestic violence and the role of clinicians:

One early theory suggested that identification in medical settings was difficult because battered women were reluctant to discuss the real cause of their injuries. Yet researchers have used simple interview techniques and questionnaires to uncover substantial rates of domestic violence in various medical settings, suggesting that identification was not so difficult after all (Flitcraft 1993)

The same author also notes dryly that the ‘high rates of participation in domestic violence research’ belies the concern that ‘patients would be offended by questions about violence at home’ (p. 155-156). Accordingly, this report includes available resources used by researchers in the section below dealing with the research evidence for particular tools.

The experience of ‘screening’ for domestic violence in healthcare settings suggests some of the issues in screening, identification and assessment, though clearly there are many others for crisis accommodation services. By its very nature domestic violence can be difficult to discuss in any service setting.

That some women in domestic violence situations conceal that fact through fear of losing custody of their children is well-documented (Peckover 2003, Humphreys 1999, Stanley 1997). United Kingdom health literature suggests the very 'private' nature of domestic violence, urging health visitors to 'be more proactive in their questioning techniques' (Frost 1999). There are related issues in this area such as how to handle a child's confidences about domestic violence where parents have not reported such matters to a worker (Carlson 2000). The whole matter of identification of domestic violence also carries with it considerable duty of care issues: given the higher incidence of child abuse and neglect in domestic violence situations, professionals need to know and understand laws about reporting child abuse to child protection authorities (McAlister Groves 1999).

Those women that do seek help, often only when the violence has escalated, from health and welfare services for example, do not always receive appropriate support or protection, particularly accessing specialist services through referrals, including help for their small children (Peckover 2003, Humphreys 1999). Black and Asian women experience particular challenges accessing services because of cultural and language barriers as well as discrimination (Peckover 2003, Humphreys 1999).

In part, such issues relate to a lack of professional skills in the area of domestic violence (Peckover 2003). The research suggests that social services too often poorly *recognise* domestic violence, a problem that is about professional training, organisational priorities and cultural attitudes within social service professions, as much as the issue of domestic violence getting lost in particular techniques of assessment (Humphreys 1999).

It has also been noted that professionals have difficulty identifying children who have been exposed to domestic violence, and may be uncertain about interpreting their problematic symptoms (McAlister Groves 1999). In a study of children presented to urban paediatric emergency departments it was found that the children of women experiencing domestic violence 'had no distinguishing complaints in the emergency department suggesting that there was violence in their families' (Duffy et al. 1999). However, other studies note that specific child behaviours associated with domestic violence fall into the categories of both internalising and externalising behaviours though, of course, such behaviours are not themselves always a signal of domestic violence:

- *externalising behaviour* included aggressiveness and other behaviour problems ranging from temper tantrums to fights
- *internalising behaviour* included depression, suicidal behaviours, anxiety, fears, phobias, insomnia, tics, bed-wetting, low-self-esteem (Fantuzzo and Mohr 1999)

Other behaviours associated with children's exposure to domestic violence are impaired concentration, and lower achievement on measures of verbal, motor and cognitive skills (Fantuzzo and Mohr 1999).

Specific clinical issues to do with domestic violence exposure in young children are not as well-researched as they need to be. For example, it has been noted that there is little research into the traumatic symptoms of exposure to domestic violence in very small children: ‘research on trauma symptoms in children younger than 6 who have experienced any traumatic effect is very minimal, perhaps due to problems in conceptualising traumatic symptomatology in young children’ (Levendosky et al. 2002). Yet as noted by Scheeringa and others (Scheringa et al. 1995) who reviewed the literature for post-traumatic stress disorder in children younger than 48 months, evidence of severe impairment can be found ‘in almost all such reports’. In connection with this, research has questioned the capacity of clinical tools for assessing post traumatic stress disorder in preschool age children exposed to domestic violence (Levendosky et al. 2002, Scheringa et al. 1995)—as noted later in this report. Other studies of post traumatic stress disorder in children identify three clusters of symptoms: ‘re-enactment of the traumatic event; avoidance of cues associated with the event or general withdrawal; and physiological hyperactivity’ (Perry and Azad 1999):

Children with PTSD may present with a combination of problems including impulsivity, distractibility, and attention problems (due to hypervigilance), dysphoria, emotional numbing, social avoidance, dissociation, sleep problems, aggressive (often re-enactment) play, school failure, and regressed or delayed development. (Perry and Azad 1999)

Yet notwithstanding these challenges and qualifications, identification and assessment at least remain a critical challenge in the crisis accommodation service setting. Being able to assess that nature of the child’s exposure to domestic violence is important to knowing how to respond, including through referrals: for example, and as one study notes, ‘because the duration and intensity of family discord are predictors of children’s adjustment, it is important to assess thoroughly the nature and extent of violence to which the child has been exposed (Carlson 2000).

Models of best practice

Not surprisingly, given the above discussion, for some years the dominant models of best practice in this area have been about screening in healthcare contexts (Parkinson et al. 2001). Best practice in ‘screening’ in the UK (specifically in healthcare contexts) is guided by three principles:

- the assessment or screening tool should be acceptable to the population
- the assessment in its entirety (not just the screening tool) should be acceptable to practitioners
- there should be an effective treatment/intervention available (Ramsay et al. 2002).

Another paper identifies similar principles that apply generally to the robustness, validity, and utility of screening tools (Taft 2002).

The importance of focussing holistically upon ‘the whole child’ has been emphasised in the research (Fantuzzo and Mohr 1999). As noted in one review of the literature (Jaffe et al. 1990)

...assessment should be as comprehensive as possible and cover all areas of a child's development in keeping with research that shows that child witnesses can develop adjustment difficulties in almost any area of development. In particular, professionals should assess for post-traumatic stress symptoms such as nightmares about the abuse, dissociation, depression, self-esteem, poor social skills and peer relationships, and behavioural problems, all of which have been shown to be elevated based on the literature (p. 334).

One best practice holistic assessment approach is the 'developmental approach' whereby the child's performance of age-appropriate tasks across physiological, cognitive, emotional and social functioning is assessed (Fantuzzo and Mohr 1999).

The term 'holistic assessment' can mean focussing on multiple symptoms and needs presented by the small client, but it can also refer to the importance of involving a number of relevant professionals. There is also a strong emphasis in the literature upon inter-professional assessment (and intervention) that involves, for example, school as well as health and mental health professionals working together (McAlister Groves 1999). Some broad frameworks such as the UK Government policy based *Framework for the Assessment of Children in Need and their Families* are available that aim to help assess the developmental needs of the child and parental capacity to respond to the developmental needs of the child (Horwath 2001).

Clearly, the tasks of identification and assessment should separate out the mother and child where appropriate. The literature suggests that services that approach the mother and child as if they were one and the same client miss the point that the interests of men, women and children in domestic violence situations are not the same—for example, in cases where the mother is the perpetrator of child abuse (Humphreys 1999). At the same time, a service focus on child protection that does not include attention to woman protection is also contra-indicated (Humphreys 1999).

The role of the abusing parent in the assessment process in particular is complex and controversial. The lack of participation of men in the assessment process has been cited as a key issue in the usefulness of residential assessment (Humphreys 1999). However, other studies caution that therapists (at least) should 'not attempt to serve the needs of all parties (for example, the batterer, the abused parent, and the child) because doing so may lead to conflicts of interest' (McAlister Groves 1999).

A number of forms offering different ways of assessing the child and its mother's needs in Australian service contexts are given in a previously cited review of models of best practice in this area cited (Gevers 1999b). However, and as suggested by the guidelines for screening in healthcare settings, many accounts of best practice emphasise that assessment is not an end in itself. For example, best practice involves assessment that leads, where appropriate, to development of a support plan for each child that is non directive, responsive, and does not label the child (Gevers 1999b).

Research evidence for particular tools

This section explores the research evidence for particular tools. However it is not intended to offer up a single tool as the definitive assessment tool for Tasmanian IEA Women's SAAP services.

As has been noted ‘It is seriously doubtful whether any one form of words will be more or less comfortable or even desirable for every practitioner and appropriate to every culture, age and class of women’ (Taft 2002). The advice for clinicians is to use clinical judgement and never to let the results from an assessment tool outweigh that judgment (Sherin et al. 1998). Such advice has some relevance to non-clinical settings where such tools may also have serious limitations for particular clients or groups of clients, or service settings.

Despite these qualifications, knowing what the literature says about the nature and value of particular tools for measuring or identifying domestic violence can be very helpful to practitioners wanting to move practices forward. The following notes on these tools separate out tools used for working with adults (mostly the mother of the small child) from tools available to work with the small child, with the latter category by far the smallest. Further, as can be seen from the list below, many of the tools for working with adults have not yet been properly validated, with the exception of the first mentioned tool—the Conflicts Tactics Scale.

Tools for working with adults (mostly clinical tools for healthcare settings as well as tools used by researchers):

- Conflicts Tactics Scale (CTS) is the most widely used and validated tool (Koenen et al. 2003, Indermaur 2001, Sherin et al. 1998, Hegarty et al. 2000); it measures verbal reasoning, verbal aggression and violence (Jaffe et al. 1990) though it has been criticised for measuring overt rather than covert forms of abuse (Hegarty et al. 2000); one study of perpetrators of domestic violence notes that studies that rely on CTS are limited to frequencies or counts of ‘aggressive acts’ and do not include other relevant measures such as the degree of force (Romans et al. 2000) or actual injuries (Jaffe et al. 1990); this instrument is however quite old, being developed in 1980 as part of a major survey of American families (Jaffe et al. 1990); researchers have more recently used CTS-2 (Rosen 2004)
- The Composite Abuse Scale validated across three Australian populations is based on a broader definition of domestic violence that includes emotional and sexual abuse (Hegarty et al. 2000) though less is said in the literature about it
- Semi-structured identification and assessment questions have been developed by Warshaw (1998) for clinical settings, including for safety and lethality of the victim’s situation, and apparently based on professional experience of the author, though no research evidence for their use was included
- HITS is a short domestic violence tool in the form of a paper and pencil instrument designed for use in family practice settings with some evidence for its validity in relation to the CTS (Sherin et al. 1998)
- Standardised clinical interview protocols have been developed by the Multi-Site Child Development Project and are designed to help mothers feel comfortable about reporting child maltreatment taking place in children 0-5 years old; these have been used by researchers who had to secure intervention if maltreatment was occurring (Koenen et al. 2003)
- University of Michigan Composite International Diagnostic Interview (Tolman and Raphael 2000) offers another interviewing tool
- The Severity of Violence Against Women Scales (SVAWS) is a 46-item instrument used to assess mothers’ experiences of domestic violence from threats to violent acts to sexual abuse (Levendosky et al. 2002)

- Queensland healthcare settings also use a tool aimed at identifying whether the respondent is afraid of anyone at home (Taft 2002)
- NSW healthcare tools include a tool adapted from the Abuse Assessment Screen focussing on physical abuse by partners (Taft 2002)
- Clinical diagnostic and treatment guidelines are also relevant such as those developed by the American Medical Association and Australian Medical Association (Flitcraft 1993)
- The three question Partner Violence Screen for clinical settings though a printed question in a self-administered history form is seen by at least one medical researcher as not as effective as questioning by the obstetrical provider (Mayer and Liebschutz 1998).

Tools for working with children:

Many assessment tools in the literature are either not appropriate for children or appropriate only for older children. For example, as noted in one review of the literature, the children's version of the CTS is really more appropriate for older children (Carlson 2000). Carlson (2000) also refers to a Child Witness to Violence Interview developed by Jaffe, Wolfe, and Wilson (Jaffe et al. 1990) however this interview tool requires the child to verbalise responses and so again, appears more suited to older children.

The most common assessment tool (in the context of discussions about mental health services) is a focused clinical interview exploring the child's experiences with the violence, supplemented with data collection from other sources, including parents and teachers (McAlister Groves 1999). In the late 1980s Pynoos and Eth developed a 90 minutes child interview technique for use with children 3-16 who have been recently traumatised (not only by domestic violence), which involves free drawing and story telling initially (Pynoos and Eth 1986). However, it is clear that handling such an interview requires high levels of professional skill and that any such techniques with children should involve trained professionals—they raise serious ethical challenges, including duty of care issues.

One of the few better-known tools for working with children is the Child Behaviour Checklist (CBCL) for assessing children's emotional and behavioural functioning, with scores that can be grouped into subscores of internalising/externalising behaviours (Koenen et al. 2003, Levendosky et al. 2002). The CBCL can involve a maternal report of the checklist and has been adapted and used for very small children 2-5 years, with some modification of items for the 2-3 versus the 4-5 age-group (Levendosky et al. 2002). As noted by one researcher (Jaffe et al. 1990), the CBCL has been used by researchers and mental health practitioners because

...the adjustment problems of these children described by shelter staff and clinical observation can be well conceptualized by the CBCL's internalizing and externalizing behaviour problem scales and in social competence scales...The CBCL and other collateral reports of children's adjustment need to be complemented by direct interviews with children and observations by other significant adults in each child's life, such as his or her teacher. (p. 78)

However, again, complementary techniques such as the Child Witness to Violence Interview tend to focus on children older than those that are the subject of this study (Jaffe et al. 1990).

However, the capacity of CBCL (Levendosky et al. 2002) and another tool for DSM-IV (Scheringa et al. 1995) to assess very small children's post traumatic stress symptoms has been questioned. DSM-IV is a tool that suggests re-experiencing symptoms in children might include:

- repetitive play, particularly with traumatic themes
- nightmares and
- 'trauma-specific reenactment' (Levendosky et al. 2002).

Levendosky and others (2002) also note that 'The Zero to Three' National Center for Infants, Toddlers, and Families has developed criteria for post-traumatic stress disorder in young children 0-3 (though no such criteria exists for those 3-12). Scheeringa and others (Scheringa et al. 1995) have also developed alternative criteria for post-traumatic stress in children aged 0-3.

This instrument can be used with mothers to measure a range of behaviours such as playing and talking about a violent event; showing a loss of previously acquired skills since the event such as toilet training, developing fear of separation from primary caregiver since the violent event (Levendosky et al. 2002).

Finally, the researcher would point readers to tools for identification and assessment (as well as intervention) in the resource manual cited previously in this report and listed in the references at the back of this report *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers* published in San Francisco by the Family Violence prevention Fund. Designed for healthcare contexts, its authors claim it can be adapted to many other settings (Warshaw 1998). It is available at <http://endabuse.org/programs/display.php3?DocID=238> though systematic evidence validating these tools were not found.

Assessment tools already in use by Tasmanian SAAP services

Assessment practices in Women's IEA SAAP services suggest a range of practices and issues, summarised as follows:

- SAAP services are using standardised SAAP forms such as the Crisis Assessment Form as part of the Common Assessment Tool (CAT) (with a referral form as part of the CAT tool, though some agencies fax through the entire CAT form); the CAT is used with a locally designed follow-up interview tool or else A Child Assessment Indicator tool modified from other similar service settings; the Accompanying Child Form and the Family Support Child form is also used with some modifications; the information from these forms is wide-ranging, though this information is not always shared with other services; the answers given to other informal questions not on these forms are typically recorded in the case notes.

- However findings from the evaluation of SAAP IV in Tasmania, Woodland (2006) stated that:

The Common Assessment Tool has enhanced the capacity of agencies to assist clients to identify their specific issues and support needs. It formed the basis for the development of individual case plans pp.48

- Typically, recording of basic information begins as soon as the mother and child arrive at the service, though all the different parts of the formal assessment forms may not be completed until a few days after residence commences; informal observations begin immediately.
- The usefulness of standardised forms is an issue for Women's IEA SAAP services: for example, much assessment information comes sporadically throughout the client's stay and may be recorded in the case notes which do not necessarily translate into the assessment process.
- Informal observation can include activities such as games with children using, for example, cards (St Luke's resources available at <http://www.innovativeresources.org>) and/or drawings by the child.
- Informal observation can often lead to external referral and on-site visits from relevant professionals such as social workers.
- A broad range of staff are involved in the formal and informal assessment of the small child.
- Attempts to get parents to attend external programs where formal assessment can occur are not always successful. Barriers can be transport, availability and access of childcare, the mother's fear of the child being taken away, as well as natural needs for seclusion and protection after trauma.
- SAAP agreement restrictions to residential stays of six weeks are also a key factor in difficulties developing links with external agencies; the ways in which restricting client stays to six weeks adversely impact on SAAP services was also flagged in a recent study of service provision (Love 2003) which states that 'women and children will often have moved on from the shelter before referrals for counselling and support for children can be actioned' (p. 40).*
- The quality and nature of SAAP accommodation itself is a key factor in the success of assessment practices, which require privacy and space.
- The six-week IEA stay is a recommended target, data indicates that the majority of clients exit into transitional accommodation within approximately 2 weeks. No Woman and child/children is exited from IEA without an on-going support plan in place. It should be noted that Women's IEA services are one service type among a number that make up the SAAP service system's continuum of support in Tasmania. On entering IEA clients are linked to case planning and support and transitional support services.

There is an expectation that transitional support services will provide on-going support needs of clients (p9). (Department of Health and Human Services Tasmania)

Suggested tools that may be useful to SAAP contexts

The researcher would suggest that practitioners in SAAP services explore the value of the Child Behaviour Checklist (CBCL) for assessing children's emotional and behavioural functioning discussed in this report (Koenen et al. 2003, Levendosky et al. 2002), as well as other tools listed in this section, particularly the Conflicts Tactics Scale, these two being the most commonly referred to tools in the literature scanned as part of this small project. On the basis of this research, it can be concluded that these tools appear more likely to work to develop broader staff capacities to recognise and respond to the needs of small clients. Clearly, however, it is beyond the scope of this small study to trial and evaluate the use of any such tools, however adapted, in the complex settings of crisis accommodation services—that should be the function of a second stage of research and must involve permission from the necessary organisations. As the information below will suggest, the development of these tools has been the result of very large investments of time and expertise (including expertise in the scientific validation of instruments) by particular individuals and organisations and naturally they are protected by copyright. However, the present study has obtained sufficient evidence to support the value of practitioners examining such tools for professional development purposes (i.e. reading about the tools and discussing them in staff meetings to explore their implications for practices), pending further exploration of their usefulness in Australian SAAP services in a second stage of research.

Information about the Child Behaviour Checklist

For ordering versions of the CBCL suitable for smaller children and related tools see <http://www.aseba.org/products/cbcl1-5.html>

For information about the organisation (the Achenbach System of Empirically Based Assessment or ASEBA) that has developed and now sells these products see <http://www.aseba.org/index.html> and

http://www.aseba.org/ABOUTUS/aboutus_start.html

For more detailed information on the empirical validation of the CBCL generally see <http://vinst.umdj.edu/VAID/TestReport.asp?Code=CBCA>

Information about the Conflicts Tactics Scale

For details of the instrument and information about who to contact to order it <http://pubpages.unh.edu/~mas2/CTS15.pdf>

For information about its empirical validation <http://pubpages.unh.edu/~mas2/CTS4.pdf>

Key supports and links to other children's services

Key issues

The research emphasises the importance of professionals in this area working with support networks of other professionals (McAlister Groves 1999). Accordingly, and in line with the research brief, the purpose of this section is to help develop new directions for SAAP practices in this area. This particular section of the report canvasses some of the issues in developing inter-agency responses to the needs of small children exposed to domestic violence.

Any analysis of the mechanisms and dynamics of referral and inter-agency support in this area needs to account for the situation of the small child in a family that is most likely economically disadvantaged. A key issue in accessing appropriate support and making referrals in the USA literature at least is the lack of access of families that may not have the financial resources to afford the ideal service. These economic realities interact with other issues of service access. For example, 'children who are suffering, but whose symptoms do not fit into a defined diagnostic category' may experience particular problems (McAlister Groves 1999), especially in the context of their family's economic situation.

Women who have experienced domestic violence (recently or in their longer personal histories) can be found disproportionately among those on welfare (Pearson et al. 1999); it is well-known that domestic violence includes controlling behaviours aimed at preventing women from being economically self-sufficient (Tolman and Raphael 2000). Research has shown for a long time that domestic violence seems to work to depress women's socioeconomic and occupational status (Lloyd 1997). For example, domestic violence is indicated in the literature as a factor affecting women's success in finding and keeping jobs (Sable et al. 1999, Moe and Bell 2004). Conversely, positive action in supporting women to find work, including through a broad range of welfare-to-work supports (childcare, transportation, economic supports) are indicated for reducing not only poverty, but also domestic violence (Riger and Staggs 2004, Gennetian 2003, Scott et al. 2002):

The ability to find and maintain employment during or after an abusive relationship is of paramount importance to women seeking to escape domestic violence. Women who have adequate financial resources will likely find it easier to live independently from their abusive partners, at least economically if not emotionally, socially, and legally...Unfortunately, establishing any level of independence from an abuser, such as by working, runs counter to his goals of establishing power and control through physical and sexual assault, social isolation, emotional degradation, and economic dependence. (Moe and Bell 2004)

There is also research indicating that 'battered women's attempts to work have been correlated with greater and more severe abuse' including for those in crisis accommodation situations (Moe and Bell 2004).

This vulnerability is also demonstrated by research demonstrating the dangerous dependencies that can develop as women in domestic violence situations struggle to move from welfare to work, and evidence of ‘how women ended up relying on men who have been abusive to them either for instrumental assistance or for more direct financial assistance as they struggled to move from welfare to work’ (Scott et al. 2002)—perhaps a particular issue in the USA’s particularly punitive welfare system with its program of ‘welfare reform’. Further, the literature provides indications suggesting that a minority of women fear harm will come to them if they pursue child support (Pearson et al. 1999).

Such literature suggests that women who have experienced domestic violence and their children are affected not only by economic issues in their efforts to develop positive futures, but also by a lack of related social supports (Mitchell and Hodson 1983) which in turn can also affect their capacities to obtain assistance from community services.

The difficulties of developing wide-ranging, holistic, inter-agency responses to the needs of clients who have experienced domestic violence also include the mother’s previous negative experiences with such services (the lack of satisfactory service responses noted earlier in this report being one element of this). For example, at least one study (Hoyle and Sanders 2000) suggests that ‘many women do not seek criminal sanctions because sanctions are unlikely to help end the violence’ (p. 14).

However, the barriers to facilitating inter-agency responses are also about the limitations of services themselves, also indicated by earlier discussions in this report, for example in relation to capacities of services to identify and assess the small child who needs assistance following exposure to domestic violence. In relation to mental health needs there are concerns that centres may be addressing the needs of the child in an ad hoc manner, rather than in systematic ways where the child’s needs can be properly met through a formal program (Saathoff and Stoffel 1999).

Notwithstanding these barriers it is important to emphasise the critical role of inter-agency approaches to the needs of the small child. The fact that domestic violence is part of a complex set of interacting factors may also mean that changing one factor such as access to support services can positively affect other factors, as suggested by the discussion of poverty above. This point is relevant not just to domestic violence, but also to the whole host of inter-related issues that such clients present. For example, one American study found that responding to women’s needs not just for access to substance abuse treatment but also for a broad range of social services was important to effective substance abuse treatment for women with children (Marsh et al. 2000).

As noted by Lemon (1999):

For these children to receive the interventions they need, comprehensive community responses that include law enforcement, domestic violence advocates, court personnel, and others must be in place. Professional training about domestic violence and its effects on children should be mandatory for everyone who comes into contact with these cases. This includes attorneys, judges, mental health professionals, child advocates and police.

Furthermore, for collaborative approaches to be successful, cross-discipline training is needed to develop greater understanding of the limitations and capacities of each response system (Lemon 1999).

Models of best practice

There are models of best practice in developing broader community responses to domestic violence itself though these very rarely specifically target the needs of small children. One such study (Clark et al. 1996) suggests the importance for ‘domestic violence service providers and agencies’ of

- energetic involvement in cross-agency responses
- practicing inclusive practices in dealing with other agencies
- engaging in a cycle of continuous reflection and improvement of practices (since many community responses today to domestic violence are rooted in the seventies).

The literature suggests that best practice in this area is about utilising a broad range of services relevant to the needs of women and small children with domestic violence issues such as:

- *Child care services* (Humphreys 1999) including pre-natal care programs (Flitcraft 1993).
- *Medical and broader healthcare services* (Humphreys 1999, Clark et al. 1996); for example, a key direction identified in one study was the integration of ‘case management practices between birthing services and the domestic violence system’ (Taft 2002).
- *Child protection services* (Humphreys 1999); these can involve collaboration with these agencies in cases of child maltreatment, educating children to help them promote their own safety, and assisting families with access to legal protective mechanisms (Saathoff and Stoffel 1999).
- *Child welfare services*, such as child support enforcement services (Clark et al. 1996).
- *Education services*; the literature refers to inter-agency collaboration relevant to achieving the service’s educational goals, including helping children keep up with their schooling, identification of special needs in education, as well as advocacy on school administrative matters; participation in an education program can be beneficial for children because it brings a focus on their own personal growth (Saathoff and Stoffel 1999);
 - in Cleveland, Ohio, a shelter named Templum has an on site schoolroom for resident children in kindergarten to eighth grade (Saathoff and Stoffel 1999);

another crisis accommodation centre called Rainbow House in Chicago also offers on-site educational opportunities to young children, including an infant-mother program as well as a preschool intervention; such models involve collaboration with local school authorities to provide on site classrooms, such as one available in Toronto Canada where two shelters have collaborated with local school authorities to make a special classroom, with individualised education programs, counselling group sessions, social skills training, as well as after school activities (Saathoff and Stoffel 1999)

- there are also mental health models for developing behavioural interventions such as that developed by the Bazelon Center for Mental Health Law in Washington D.C, USA which involve developing a behavioural intervention plan based on functional behavioural assessment in ways that give schools key responsibilities for interventions (Bazelon Center for Mental Health Law 2003).
- *Men's counselling and support groups* (Humphreys 1999).
- *Alcohol and substance abuse services* (Humphreys 1999, Flitcraft 1993).
- *Mental health services for parents and children* (Flitcraft 1993);
 - in Pittsburgh, Pennsylvania, the Healthy Tomorrows program has provided children in crisis accommodation with medical screenings by interns from the local children's hospital, as well as follow-up medical support 'free of charge' (Saathoff and Stoffel 1999) (given that 'fee for service' is more an issue in the USA medical system)
 - the Rainbow House in Chicago has an on-staff child advocate that evaluates children's health status within 72 hours of their arrival, with follow-up medical treatment (Saathoff and Stoffel 1999).
- *Legal advice and redress services* (Peckover 2003) such as criminal justice agencies, courts and the police.
- *Physical protection through police or other social service intervention* (Peckover 2003);
 - it is worth noting that Tasmanian police use a risk assessment tool (RAST) and a safety audit at every domestic violence incident; there are specialist family violence units within Tasmania Police though the co-ordination, data collection and analysis is done by the Department of Justice (University of New South Wales 2005)
- *Protection through refuge and other alternative accommodation and resources* (Peckover 2003), including long-term accommodation services (Humphreys 1999); this can include working with other crisis and bridging accommodation services.

- *Employment and training services* (Clark et al. 1996).

What referral services exist in Tasmania? A study of service provision in Tasmania for children exposed to domestic violence (Love 2003) advised following a survey of services for referral, that:

In addition to mainstream domestic violence services (crisis Accommodation*, S.H.E, Survivors and Domestic Violence Crisis services) and the Child and Adolescent service, the following services were indicated:

- Department of Health and Human Services - Child, Youth and Family Services – Intake and Assessment.
- Department of Health and Human Services - Parenting Centres.
- Department of Health and Human Services – Child Development Units. • Department of Education - school Guidance Officers and Social Workers.
- Anglicare counselling services.
- Centacare counselling services.
- Holyoake (South).
- Family Support Services
- Family Links (North).
- Kids Helpline.
- Migrant Resource Centre support worker.
- Phoenix Centre (South).
- Community Health Centre.
- East Coast Counselling Service.
- Narrative Centre (Private practice - South), Pathways (Private- South) or other private counseling.
- PaKT and ReConnect (Colony 47 services – South).
- Relationships Australia.
- Sexual Assault Support Services.
- Wyndarra Rural Health Service. (p.37)

This study exhaustively reviews the nature and extent of many Tasmanian services; for counselling, for group work, for parental programs, and so on, and it is not the intention of this author to reproduce that study here (Love 2003). However, it is worth noting that rural areas of this state were identified as having particularly acute problems accessing services in urban areas, and the related problem of ‘the dependence which children have on adults for assistance in accessing support’ (p.58):

There is a general recognition that specific domestic violence services are not available to rural areas, including crisis services and services available to provide ongoing support post-separation. Women and children leaving violent homes are sometimes forced to leave the rural area. This is particularly traumatic for children, as they are forced to leave the home environment, school, friends, informal supports and often many of their toys, pets or personal effects. (p.60)

It should be noted that since the completion of the research and report by Love (2003) DHHS has established the Family Violence and Counselling Support Service which provides a specialist trauma counselling service for children effected by Family Violence in Tasmania.

**Crisis accommodation in the Tasmanian SAAP service system is referred to as Immediate Emergency Accommodation for Women. Its target population is all women who are homeless, including those women and children effected by Family Violence.*

What does the literature tell us about how such inter-agency collaboration can be facilitated?

A key strategy indicated by some American community responses to domestic violence is regular monthly meetings of people from different community agencies to coordinate community responses to domestic violence, with a coordinator of these meetings. This facilitates, for example, the organisation of domestic violence workshops, development of better information sharing systems, formal and informal sharing of technical expertise, joint fund-raising efforts (Clark et al. 1996).

Other strategies include the development of referral lists and posters, leaflets and contact cards (Peckover 2003). Practical suggestions for maintaining brochures and resources cards are referenced in this report (Warshaw 1998). Best practice also refers to the importance of a register of services and programs, or periodic publications of text describing these, such as those given in other states (Gevers 1999b).

The literature also provides details of models of inter-agency support relevant to the challenges facing Tasmanian Women's IEA SAAP services. For example, an internationally known model call 'The Duluth Model' takes a community-capacity building approach to domestic violence that includes enhancing networking among providers (Shepard and Pence 1999). However, of particular interest is an innovative approach in Michigan that provides a best practice model of how different agencies in the area of family services and child protection can work together i.e. child welfare workers and domestic violence services program workers who traditionally have not worked together, in American contexts at least. The model, which focuses upon the safety of children through an emphasis on the safety and self-sufficiency of their mothers, involved:

- Development and implementation of state-wide cross-training in the areas of domestic violence for 'family preservation and child protection staff'; and on family preservation and child abuse and neglect for 'domestic violence staff'; this included informal familiarisation and professional development such as information and literature sharing, and visits to each other's programs to discover, for example, common goals and philosophies;
- The delivery of 'intensive preservation services' to women and children exposed to domestic violence through direct referrals from domestic violence services;
- Developing child protection services in ways that will support collaborative training and other program initiatives.

One key area of best practice indicated by the Michigan experience is crosstraining and familiarisation with different related programs.

Use of training supports is also important: for example, the Michigan experience involved development of a training product called *Domestic Violence: A National Curriculum for Family Preservation Practitioners* (Findlater and Kelly 1999). Though this document, dated 1995 is now somewhat out of date for the present purposes, it can be examined as one of a range of resources useful to developing a training program in Tasmania.

Achieving the goal of different agencies working together in this way requires considerable resources and long-term commitment. The Michigan experience took six years of perseverance in policy development, training and resource sharing before the collaborative model was fully functional. It also involved the support of a larger context: legislature, governor's office, law enforcement and courts (Findlater and Kelly 1999).

The literature also refers to a program in Boston, Massachusetts that involves an inter-agency approach to case management of child abuse cases involving domestic violence: teams of 'CPS staff, police battered women's advocates, batterers' intervention providers, court personnel, hospital staff, and supervised visitation providers' work together in a team to 'use each other's expertise to design effective case plans and to improve case practice' (Lemon 1999).

There are also services that have taken the notion of inter-agency collaboration to its ultimate geographic expression, suggesting how much the 'tyranny of distance' works to affect the informal and formal links between organisations serving the same groups of clients. For example, a multidisciplinary program operating in San Jose in California known as 'The Family Violence Center' operates as a 'one-stop-shop' for families experiencing domestic violence or child abuse i.e. it offers a range of services in one building: legal, mental health, and domestic violence services staff (Lemon 1999).

The above eclectic set of examples suggests some of the key aspects of best practice in making inter-agency responses to domestic violence happen. The next section examines the information from Women's IEA SAAP agencies about what is already occurring in Tasmania.

Key supports and links already in use by Tasmanian Women's IEA SAAP services

Interviews with staff in Women's IEA SAAP agencies suggest a complex set of practices to do with inter-agency facilitation:

- The importance of specific agencies with which Women's IEA SAAP services are already working:
 - The Family Violence Unit (Tasmania Police) offering a social worker;
 - The Counselling Unit in the Family Violence and Counselling Support Services (Department of Health and Human Services—DHHS) offering formal counselling;

- The Centre Against Sexual Assault (SAS), which offers a worker skilled in working with children;
 - The Parenting Centre (DHHS) offering therapeutic approaches to behavioural issues;
 - Kindergartens and schools, including school guidance officers;
 - Clare House for mental health needs;
 - Centacare which works with a broad range of women and children, offering counselling a groupwork; Centacare also offers programs that include the abusing parent;
 - Child health services, including general practitioners and child health nurses in community health services;
 - Other SAAP services, including Case Planning and Transitional Support services such as City Mission, Anglicare and Colony 47;
 - Counsellors; e.g. in private practice (who are also used by DHHS);
 - Child protection services: Child and Family Services (DHHS);
 - Legal services: legal aid, women's legal services, including indigenous women's legal services, and solicitors in private practice;
 - Childcare services, including for mothers with special needs children, such as Kennerly children's services (respite care);
 - Aftercare program services such as those offered by Good Beginnings which provides volunteers for aftercare, or Centacare aftercare programs; clients of crisis accommodation services can return up to twelve months or even years after exit to obtain ongoing support from the crisis accommodation service, given the relationship of trust and safety that has been established.
- The value of having access to professionals from a wide range of areas (legal professionals through to alternative healing therapists) who can visit on site and the fact that there are not enough of them; this is particularly important given that intensive support and education in the crisis accommodation service is needed by some clients who may be reluctant to attend external services.
 - The general lack of programs designed for children aged 0-5 years in a context where the focus is often upon parenting skills.
 - Again, the barriers clients experience such as lack of transport and fear of the child being removed from the parent, which can prevent them from attending externally offered programs.

- The fact that not all children including those with mental health needs and those with non specific behavioural issues can have their needs met in a timely fashion—such issues were also noted in a recent review of service provision in Tasmania for children (Love 2003) which noted that ‘non acceptance of a referral after a significant waiting period for assessment is not a positive experience for children or parents and may mark the end of their willingness to seek support’ (p.41). The general overburdened nature of services which interacts with the timing issues presented by the short nature of crisis accommodation stays; this is a particular issue for access to many services such as health services (notably general practitioners and dental services) as well as other services such as Reconnect, even extending to access to schools, including pre-schools.
- The fact that referring a child to an external professional may not be appropriate when what is needed is a happy and safe environment offering consistency and routine.

Practical suggestions for improving key support and links to other children’s services relevant to Women’s IEA SAAP agencies

The researcher’s recommendations, bearing in mind the literature on best practice and the issues raised by Women’s IEA Tasmanian SAAP services, are as follows:

R1. That SAAP agencies have regular community network meetings with other relevant agencies to develop improvements in co-ordinated responses to the needs of small children, such as timely referral responses, on site visits, development of programs tailor-made for small children, and professional training in the functions of collaborating agencies; that this collaboration place special emphasis on including education services to help design better access to pre-schools in particular

R2. That a register of agencies be developed for referral of small children and their mothers exposed to domestic violence, including agencies offering on site visits

R3. That this report be referred to relevant Government offices, including the Department of Health and Human Services, for consideration of how to address the problem of the general overburdened nature of critical human services that are best positioned to meet the needs of small children exposed to domestic violence.

Interventions, including key activities and therapeutic play modules

Key issues

It is worth beginning this section on best practice in interventions by citing the words of a professional who describes what happened to a small child in a context where services relied upon and privileged therapeutic approaches that were about maternal resolution of trauma, as if this had to happen before the child could be helped (McIntosh 2000):

Many years ago, on my first day as a fresh post graduate researcher in a family support agency, the director whisked me and several others suddenly into a car, heading urgently for a client's house where a domestic violence incident was in play. When we arrived, the husband had fled, leaving nothing unbroken in the house, including his family. We found his wife in a corner, with her throat cut by a broken kitchen plate. Her two and a half year old son was in another corner, with the other half of the plate. He held the plate up to me and then put it to his throat, saying 'Daddy cut cut'. He repeated this over and over until a worker took him outside to play, while the glass was swept and police called.

Through the next days and weeks in a refuge the boy was distracted with toys and often cuddled, but not spoken to, not played with about what he had seen. Not de-briefed. Why? He was only two and a half. (Why really? Because we aren't equipped with the specialist skills to do it, nor the resources to obtain or attract the skills). The weeks turned to months of departmental assessment, to see whether the mother was capable of leaving the violent relationship and protecting her son.

When I saw him three months after the incident, the boy had the hallmarks of a disorganised child, who did not know how to go about getting care from his mother. He was extremely frightened of loud noises but would play a dangerous and repeated game of banging on the windows. He had still had no treatment. Mother received daily counselling and active support to parent her son, whose experience she still could not think about.

Three years later working in a child psychiatry department, my consulting team was handed a referral to see this same boy for autism assessment. He had continued in the care of his mother primarily. She had left his father, although father was granted court ordered access upon his release from jail. Contact was unsupervised for three hours each fortnight. The court's argument: he had never been violent to his son. The boy indeed presented with autistic-like defences, cut off, highly dissociated with obsessive traits, but he was not autistic. The psychiatry department did not feel it could offer treatment until all legal and protective matters were cleared up. Community and family support agencies did not have the expertise to deal with the boy, although continued to support the mother. In my view, this was a woman who, through her own history of unresolved trauma, would not for many years if at all be able to form a capacity to think about her son in the way that was needed. (p.10-11) *spelling of defences above

The case demonstrates the importance of appropriate interventions for very small children, and equally the ways in which services may be operating under assumptions that prevent such interventions from happening.

Yet interventions in this area are some decades old. The first public strategy for domestic violence in the USA was convened in 1985, emphasising tools for intervention and prevention (Flitcraft 1993). America has a National Directory of Domestic Violence programs (or at least did have in 1997)(Saathoff and Stoffel 1999). However, the fact that domestic violence as it affects very young children is a growing area means that (in the past) there has not been uniform standards of care or comprehensively listed programs (McAlister Groves 1999). The same conclusion can be made about a number of other western countries, including Australia.

Today it is recognised that best practice in this area should not be dependant on the child showing signs of abuse or distress (McGee 2000).

At the same time, it is also worth noting research stating that not every child identified as being exposed to domestic violence will need intervention (McAlister Groves 1999).

The task of developing sound interventions for small children is difficult in the context of a research literature that is primarily diagnostic and does not take a service delivery focus. As noted in a previously cited review of the literature (Carlson 2000) we know quite a bit about the nature and effects of domestic violence but ‘much less has been written about effective intervention with children who have been exposed to partner violence than about its effects’ (p. 333).

However, it is certain that crisis accommodation services are becoming more attuned to the specific intervention needs of the accompanying child. The child who reaches the shelter of a crisis accommodation service for women will, according to some studies, be living in a service where almost 80% of women are accompanied by one or more children (Saathoff and Stoffel 1999). Increasingly, such services offer some type of child-focussed program (Saathoff and Stoffel 1999). In the late 1990s these services had already grown in the USA to include day-care, after school care, recreational activities, counselling, and advocacy (Saathoff and Stoffel 1999).

Clearly though, the challenge is to provide some form of meaningful intervention in the short time frame of client stays in crisis accommodation. A key feature of shelter stays is their short duration (six weeks to three months), consistent with their crisis orientation, and their attendant focus on helping residents to make the transition to post-shelter life. Yet they offer a social context for penetrating the child’s isolation, though the unfamiliarity of shelter life can be traumatic for a child, leading to behavioural symptoms that may be inaccurately interpreted (Saathoff and Stoffel 1999).

As the previous section shows, community-based services, such as crisis accommodation services, provide a broad array of referrals and linked support services that can be described as interventions:

...legal, health, mental health, or vocational services or referrals, and assistance in finding housing, relocating, and planning for safety. Most recently, in response to increasing knowledge about the deleterious effects of exposure to domestic violence on children, community-based service providers have developed programs addressing children’s mental health, health, educational, and safety needs...[however]...most organisations do not yet have a sufficient range of services to meet children’s diverse needs. Challenges posed by inadequate funding, needs for specialised staffing, and a dearth of data on the efficacy of current intervention programs hamper domestic violence service providers’ ability to meet children’s needs (Saathoff and Stoffel 1999, Flitcraft 1993).

As the earlier discussion on the value of holistic approaches suggests, the literature supports the notion that services should be part of ‘an integrated approach...to identify pockets in the community where risk factors exist and to implement intensive intervention strategies...intervention with indigenous families needs to be a matter of highest priority’ (Indermaur 2001).

Researchers appear optimistic about progress in some key areas of the operation of crisis accommodation services, including:

- outreach and community education efforts for professionals and the broader public; these can be in schools or target adults, be about prevention or information about services available, and may involve collaborations with different community leaders and organisations, as well as professional groups and organisations (Saathoff and Stoffel 1999); outreach has been recognised as a key area where crisis accommodation services can make an important contribution to the well-being of women and children who have been exposed to domestic violence (McGee 2000)
- collaborative relationships with all agencies concerned with the welfare, health, education and protection of children.

Holistic approaches are sometimes interpreted as involving not only many services, but also the child's total situation. As suggested earlier in this report, one of the most pressing challenges that often face crisis accommodation services trying to provide interventions is the matter of who to involve, particularly in relation to the question of the role of the abusing parent. Yet even here there are indications of new practices and developments. As noted in the literature, the child's safety with the abusing parent must be part of interventions:

Many perpetrators of domestic violence will have ongoing contact with their children, and most do not understand the effects that their violent conduct has on their children. Incorporating parenting components into batterer intervention programs offers one mechanism for promoting more responsible fathering on the part of batterers. Another approach to encouraging safe and positive parent-child interactions is use of visitation and exchange centers. These relatively new programs offer supervised opportunities for parents and children to visit in a neutral, child-friendly environment. (Saathoff and Stoffel 1999)

One research paper set in social work contexts argues that

There is a growing body of evidence which testifies to the fact that fathers tend to be excluded from child protection work, leaving mothers to bear the brunt of social work assessment, monitoring and intervention procedures....Social workers who fail to include abusing fathers in their intervention are unwittingly colluding with the gender stereotypic that places responsibility for caring solely with women. In allocating women responsibility for controlling male violence, social workers are subscribing to a cluster of ideas that characterize male violence as essentially impulsive and 'natural' and denies men responsibility for controlling their own behaviour. (Stanley 1997)

The sections that follow try to identify interventions that target small children. The notion of an 'intervention' used is a broad and inclusive one. In the sensitive contexts of domestic violence, every action and inaction has consequences for the small child. As has been observed, any intervention with children in this area is known to involve confronting emotional experiences that are complex and intense (McAlister Groves 1999).

For example, at least one study (though of older children) notes the complex nature in which feelings of anger and rage are mediated in children depending on whether the conflict is adult-to-adult or adult-to-child (el-Sheikh and Cheskes 1995).

It is worth ending this section introducing the issues to do with intervention for this age group with the observation that the challenges may also involve service culture. That is, our most important challenge in Tasmania and Australia generally may be to build a culture of intervention for small children in crisis accommodation services. As a key expert in this area (McIntosh 2000) whose words were used to open this section has argued:

If you accept what I have said today about the need for early intervention with children, and the dire consequences of trauma going untreated in young lives, you may be willing to consider that the current tone of this debate needs to be altered. Mandatory reporting doesn't necessarily equal early intervention of the kind that children need. I would rather see a debate on, for example, concepts like mandatory specialist de-briefing of children and young people in violence experiences; mandatory trauma assessment; and the mandatory provision of support to children until such time as their parent's capacity to protect and to think is restored. (p.12)

Models of best practice

In a sentence, and as indicated by the last section emphasising inter-agency responses, models of best practice show that children who have been exposed to domestic violence have many and varied needs that need to be addressed by different mental health and social service professionals (Jaffe et al. 1990). Since the early 1990s interventions in domestic violence in clinical settings at least have involved 'identification, validation, treatment of medical needs, assessment of mental health needs, clear documentation, safety assessment, and referral to law enforcement and/or community-based domestic violence services' (Flitcraft 1993). A best practice manual (Warshaw 1998) for clinical and other settings describes intervention best practice in terms of a process rather than a specific 'intervention':

Appropriate intervention for domestic violence includes the following:

1. Routinely enquiring about the abuse
 2. Assessing safety
 3. Documenting the abuse
 4. Discussing options and resources
 5. Providing advocacy and referral
 6. Treating medical and mental health problems
 7. Providing for follow-up care
- (Warshaw 1998)

A leader in the field (Jaffe et al. 1990) identifies a number of therapeutic approaches that are useful for developing interventions:

- Family therapy, provided it prioritises the safety of mothers and children; this approach has not been so well-evaluated in the area of domestic violence (Kolko Trickett, P. and Schellenbach, C. 1998);

- Cognitive problem-solving skills training, particularly given the findings that children exposed to domestic violence have deficits in this area, and especially for children in a shelter long enough to build these competencies; this approach has also been used with pre-schoolers (Kolko Trickett, P. and Schellenbach, C. 1998); the literature includes references to how cognitive-based therapies work well in post-traumatic stress disorder treatment for children, though such an approach presents considerable challenges of application to the needs of very young children (Perry and Azad 1999);
- Approaches to treating post-traumatic stress disorder.

In relation to family-based therapies it is worth noting that this is as much about service orientation as anything else. As noted in a review of the literature on comprehensive models of service provision:

Family-centred practice (FCP) is increasingly mentioned as a key strategy known to be effective in supporting families, which describes *how* service providers should relate to parents rather than *what* they should provide. (p.6)

However, while helpful for actions in relation to the mother, unfortunately many therapeutic approaches often do not thoroughly identify the key actions that should be taken in relation to the separate but related situation of the children.

A review of best practice in interventions for children advises that such interventions should:

- create a safe therapeutic environment
- address safety skills, including in group interventions
- facilitate expression of feelings about the violence, including feelings children have that they are responsible for the violence
- ensure children receive any necessary specific therapy, such as trauma-specific therapy
- promote healthy problem solving and coping skills (strategies for which are not extant in the literature) (Carlson 2000) .

Clearly, SAAP staff should be acquainted with the broad range of interventions available in the key texts outlining models of service for working with children so that responses can be tailor-made to meet individual children's needs. A major Australian service development report (Gevers 1999b) outlining models of service for working with children helpfully describes different categories of interventions. This text provides many references to excellent resources for the different interventions, and therefore will not be replicated here. As for any action in relation to small children and other clients, the staff member delivering a service or making any kind of intervention must have the necessary skills, training and support commensurate with those actions.

The Gevers report (1999b) also indicates that staff implementing any interventions will need to carefully consider a broad range of safety, confidentiality and other issues to do with duty of care. The categories of intervention described are as follows:

- group work, including group work with mothers
- play therapy such as sand tray work, miniature animals, strength cards, games, puppets and soft toys
- visual arts such as drawing, painting collage and construction, clay work
- creative art such as psychodrama, imaginative pretend play, music and sound therapy, dance and movement
- cognitive and educational strategies such as story telling and books, imaginary journeys and guided visualisations, work books or worksheets, journal work, teaching of protective behaviours, as well as cognitive-behavioural strategies
- family therapy
- specific therapies that use a range of the above techniques, as well as other techniques: Client or child-centered therapies, solution-focussed brief therapy, narrative therapy, gestalt approaches (opening doors to an inner world) that include fantasy drawings and exploration of dreams, and emotional release counselling (including such methods as sand-play and breath-work) which may be more relevant to parents or small children depending on the technique being employed within these therapies
- prevention programs (Gevers 1999b).

Further details of Leslie Gevers' work, which also forms part of a national project in the early 2000s *Working with Children*, is available electronically through a website (www.ggj.biz).

Gevers' list echoes other accounts of the nature of interventions offered by crisis accommodation services (Hester et al. 2000), which add a focus on developing on site school services (Jaffe et al. 1990). The report published by Tasmanian non government organisation SHE (Support, Help and Empowerment) adds that good practice programs in Tasmanian services generally may be diverse but appear to share the following characteristics:

- Inter-agency collaboration and sharing of resources and skills.
- Child-focussed programs that work in partnership with parent/s.
- Models of practice based on empowerment.
- Extensive and continuing service networks (especially in rural areas).
- Continuous monitoring and evaluation that is documented.
- Cultural sensitivity and inclusiveness.
- Groupwork with mothers concurrent to children's groups.
- "Mobile" and flexible content (especially for rural areas).
- Access to supervision for facilitators (p.31).

Good practice programs are also given on the website of The Australian Domestic and Family Violence Clearinghouse (www.austdvclearinghouse.unsw.edu.au).

Group rather than individual interventions for children exposed to domestic violence appear to be more frequently documented in the literature. They are often described as being about support, prevention and education rather than delivering a particular therapeutic approach as such (Carlson 2000). They share the following characteristics

- promoting open discussion of child's experiences, including identifying who is responsible for the violence
- helping children deal with emotions (for example, enhancing self esteem) and consequences by, for example, reducing social isolation and shame
- reducing problematic symptoms children experience
- strengthening child's experiences with the non-abusive caregiver
- helping the child develop safety skills (Carlson 2000)
- supporting both the child and their family to create/maintain family situations free from violence (McAlister Groves 1999) including with personal safety planning (Parkinson et al. 2001).

Another leader in the field explores the common elements of group therapy used for children as: being introduced to the purpose of the intervention; labelling feelings; dealing with anger; learning safety skills; identifying and developing social support; developing social competence and self concept; understating the child has no responsibility for parental violence; understanding family violence; exploring wishes about the family; review and closure of group therapy (Jaffe et al. 1990). However, this author adds that group counselling is the most common kind of intervention for older children, namely those 6-15 years, except those who are severely traumatised, and is best suited to children with 'mild-to-moderate behaviour problems' (Jaffe et al. 1990) (p. 89). Group approaches are typically time-limited to 6 to 10 weeks, use a specific psycho-educational curriculum, and can be held in shelters, mental health clinics or social service agencies. Group therapies are not so helpful for younger children for whom individual intervention with a strong focus on parent counselling is typical (McAlister Groves 1999). The emphasis is upon making sure every child who needs it has access to age-appropriate interventions (McGee 2000). However, some group approaches can include mothers as part of the group such that parent-child relationships become the focus of the relationship (Jaffe et al. 1990). These may be more suitable for small children.

Despite the qualifications made by the extract from McIntosh (2000) at the beginning of this section on interventions, it is worth noting the emphasis in the literature on supporting mothers to help their children come to terms with domestic violence (McGee 2000). A review noted that at least two authors recommend that parents should receive parallel treatment and be aware of children's group treatment (Carlson 2000). One researcher emphasises that 'contact with the father should be on the basis of the child's interests, well-being and safety, and (often changing) wishes (McGee 2000), though clearly part of the challenge with very young children is ascertaining their wishes. What is clear is that children who participate in such interventions will need ongoing support both for themselves and their families (Jaffe et al. 1990).

There is very little literature about best practice interventions targeting the pregnant woman, however those that exist focus on multi-agency community team efforts aimed at supportive approaches to assessment and treatment of pregnancy complications, behavioural interventions, as well as interviewing techniques aimed at education intervention to support the woman to try to end the abuse (Mayer and Liebschutz 1998).

Evidence for particular interventions, including key activities and therapeutic play modules

The task of describing the evidence for particular interventions for this age group is considerable. As has been noted elsewhere in this report, researchers, including those focussing upon interventions specifically in crisis accommodation services, have commented on the dearth of evaluations of such programs (Saathoff and Stoffel 1999), including inter-systemic programs aimed at addressing domestic violence (Edleson 1995). Even outside the sphere of crisis accommodation services, researchers have observed a lack of ‘controlled outcome studies demonstrating the effects’ of such interventions for children (McAlister Groves 1999) as well as for pregnant women (Taft 2002). Another study, referring to the evidence for interventions in domestic violence more generally, noted that despite almost twenty years of program evaluations, their effectiveness is still questionable (Romans et al. 2000). These authors are, however, able to conclude that effective treatment programs focus on the safety of victims, educate perpetrators and victims, emphasise the need for participants to be responsible, and are properly linked to, and educate participants about, the criminal justice system (Romans et al. 2000).

As noted in a previously cited Australian study (Indermaur 2001), which was the first of its kind examining evidence from young people 12-20 about their exposure to domestic violence,

...we do not know whether the prevalence of these behaviours has been increasing, decreasing or remaining static. Without this information we cannot be sure which of our efforts to prevent domestic violence are effective (p. 3).

Of particular issue in the present study is the difficulty of accessing published academic research literature providing information about the post-intervention effectiveness of tools and kits commonly used by crisis accommodation services. The effectiveness of these resources, like many play activities and tools, and child-centered programs developed specifically for use in crisis accommodation settings (Becker and Eden 1994), do not appear to be explored in the academic (peer reviewed literature).

This is not to say that research hasn’t gone into the development of many resources—for example, St Luke’s resources appear to involve partnerships with researchers and consideration of a great deal of research literature—or that research evaluations haven’t been published outside the scholarly academic literature. It is to say there is a need for high quality academic research that evaluates the effectiveness of tools currently in use by SAAP services.

This research might draw upon classical research designs (randomised control/experimental studies) but it would also need to utilise innovative qualitative methods associated with such innovative social science researchers as Charles Ragin, in ways that examine the complex range of factors involved in intervention success in small populations (Ragin and Zaret 1983, Ragin 1987, Ragin Janoski, T. and Hicks, A. M. 1994, Ragin Kelle, U. 1995, Ragin Brady, H. E. and Collier, D. 2004, Ragin Lewis-Beck, M., Bryman, A. and Futing Liao, T. 2004).

Having said this, there are still significant learnings to be gained from the literature on intervention effectiveness, such as it is.

In the area of care for the in-utero child, there are indications of the value of peer mothering; advocacy and home visits have also been used with inconclusive evidence of success in the literature (Taft 2002). Individual (as opposed to group) interventions, which, as we have seen may have particular importance for very young children, are even less well-researched in the literature (McAlister Groves 1999). Specific interventions referred to in the literature include

- short-term group approaches for children in crisis accommodation situations such as those developed by Peled and others (Peled and Davis 1995, Peled and Edleson Peled, E., Jaffe, P. and Edleson, J. 1995); a major Australian report (Gevers 1999b) outlining models of service for working with children describes the approaches developed by Peled as being most commonly used in women's refuges and counselling services; again though, the more commonly used group approaches referred to in the previous section have some evidence for their success though this relates to older children (Carlson 2000, Jaffe et al. 1990)
- parenting skills training: a previously cited review refers to successful (leading to reducing externalising scores on the Child Behaviour Checklist) in-home sessions for 8 weeks conducted by a therapist-student team working with mothers and children (4-9 years) exiting domestic violence shelters, focusing on parent skills training relevant to children's conduct problems, though it also includes family evaluation, tailoring services for each family, and working with extended family members (Carlson 2000); Carlson (2000) concludes that 'effective interventions with this population must be extensive and intensive' (p. 335); another leader in the field (Jaffe et al. 1990) notes that, in relation to behaviour issues 'parent management training' appears to be 'supported by a great deal of systematic clinical research' (p. 92)
- art therapy programs: for example, the literature refers to the work of the Center for Domestic Violence Prevention in San Mateo, California, which offers an on site art therapy program aimed at helping children in shelters who have been exposed to domestic violence which focuses upon giving children a safe medium for telling their stories (Saathoff and Stoffel 1999)
- psychodynamic approaches to treating preschooler-mother pairs developed by the Child Trauma Research project at the San Francisco General Hospital, which focuses upon strengthening abilities in healthy family functioning, with some positive evaluation outcomes (McAlister Groves 1999)

- counselling therapies: for example, the literature refers to the work of the Pro Bono Children's Mental Health project in Pittsburgh, Pennsylvania, which offers another approach to meeting the needs of children in shelters based on pro bono collaborations: therapists donate an hour of their counselling time every week to child residents, continuing to treat them pro bono after the child has left the shelter (Saathoff and Stoffel 1999)
- motivating interviewing in interventions for pregnant women: at least one obstetrical study (Mayer and Liebschutz 1998) points to the value of a 'stages of change' motivational interviewing approach that appears in the work of DiClemente (DiClemente Miller, W. and Rollnick, S. 1991) for use with pregnant women wanting to develop new attitudes and personal resources during this time
- clinical approaches to post-traumatic stress disorder in children, including an individual model for young children developed by the Boston Medical Center that is an outpatient and non-shelter-based program (McAlister Groves 1999); as noted in the section on assessment, there are also clinical diagnostic and treatment guidelines developed by the American Medical Association (and Australian Medical Association) (Flitcraft 1993).

Current interventions, including key activities and therapeutic play modules currently in use by Tasmanian Women's IEA SAAP services

Interviews with staff in Tasmanian SAAP agencies suggest the following practices and issues in relation to their efforts to provide sound interventions for small children exposed to domestic violence:

- Use of referral processes for children presenting with specific needs such as speech or cognitive development needs; however, some mothers feel very threatened by the child attending a psychologist, and links to such specialists become problematic to achieve for the child given the short-term nature of crisis accommodation stays;
- Particular challenges meeting the needs of children with non specific behavioural issues;
- Use of play centres with in some services variously includes cooking facilities, toys, sand and water play facilities, a dolls corner, a painting corner; the play-centre also works to strengthen the bond between the parent and child; this can include a 'home corner' set up with toy phones; such play-centres in Women's IEA services can also include an outside play gym with cubbyhouse and sandpit and climbing facilities; however such facilities do not currently have specific SAAP funding line items, so services have to pursue other funding avenues if they cannot, for example, upgrade these facilities to meet appropriate standards;
- Women's IEA service providers in this study believe in a focus upon childhood as a time of fun for the mother and child and in the idea of fun as a fundamental right of every child;

- Development of individual programs for children (though not all children will have an individual program);
- Use of play dough therapy for aggression, as well as finger-painting and other age-appropriate art therapies;
- Use of resources from St Luke (<http://www.stlukes.org.au>) such as strength cards which deal with feelings and emotions;
- Use of dramatic play with dress-ups and puppets;
- Use of interactive play with carers asking open-ended questions in a non-judgmental environment;
- Not all Women's IEA services use games that have been designed to work as part of specific therapeutic approaches, at the same time, SAAP services staff have also developed therapeutic games for use in their own service settings;
- Not all Women's IEA services have workers living under the same roof as the parent and child which can affect the development of appropriate interventions;
- Aftercare is a significant form of continuing formal and informal contact and possible intervention for Women's IEA services, most often having an informal nature and, as note earlier in this report, extending for possibly many years or even generations.

Suggestions for interventions for Tasmanian contexts

- R4. That a register of interventions suitable for children aged 0-4 years and the evidence for them be set up by a peak body in the field of domestic violence
- R5. That, in designing suites of activities for those children who need them, Women's IEA staff be informed by leaders in this field documented in this report such as the work of Leslie Givers (www.ggj.biz) and interventions listed by The Australian Domestic and Family Violence Clearinghouse (www.austdvclearinghouse.unsw.edu.au)
- R6. That Women's IEA staff explore the value of age-appropriate group approaches used with appropriate professional support such as those of Peled, particularly for children at the top end of the age range that is the focus of this study i.e. children 3—5
- R7. That Women's IEA staff explore motivational interviewing techniques, implemented with appropriate professional support for its adult clients, particularly pregnant women exposed to domestic violence
- R8. That specific funding arrangements be made for the development of play centres at Women's IEA, including their ongoing maintenance
- R9. That the present study be used as a point of departure for a high quality empirical study of the effectiveness of commonly used tools for small children exposed to domestic violence, suitable for crisis accommodation service contexts; that this study utilise innovative social science methods that are able to deal with multi-dimensional client/service factors

Recording and reporting

Data collection issues in the literature and in Women's IEA SAAP services

As this report has emphasised, all staff should be familiar with reporting laws and the protocols surrounding them in Tasmania.

However, there is another meaning to the term 'reporting'—one that relates to data collection about SAAP service activities. This section explores the nature of the data collection activity in use by Women's IEA SAAP services and what can be done to improve it.

There is hardly any literature in the area of data collection in crisis accommodation contexts, as it relates to domestic violence, let alone the needs of small children. What exists suggests that social services poorly describe and capture domestic violence, an issue that is also about professional training, organisational priorities and cultural attitudes within social service professions, as much as styles of case management, intervention and case reporting that are not designed to respond to domestic violence (Humphreys 1999).

Yet it is clear that the language and data in which the story of the client is recorded is a powerful technique for shaping what happens to the client in the social service system. At least one manual on best practice (in clinical settings) points to the importance of records of client statements being couched in neutral language using the victims own words wherever possible (Warshaw 1998).

Up to the late 1990s in the USA there were no comprehensive sources of national data providing quantitative and qualitative information about the types of services provided, or the clients served by programs in this area (Saathoff and Stoffel 1999). Not surprisingly then, American community responses to domestic violence have included development of shared computer databases among shelters, standardising client information and allowing sharing of certain information subject to privacy and confidentiality requirements and protections (Clark et al. 1996).

In Australia data collected by the National Data Collection Agency clearly shows the type of services provided or support arranged by each SAAP service for those seeking assistance due to family violence. This includes services provided other than emergency accommodation, either during a client's stay in a Women's IEA or during their transitional phase into stable accommodation. However attention to children in national SAAP data collection is a relatively new initiative, linked to the lack of information on service needs in this area (Norris et al. 2005). The Norris review notes the implementation in 2005 of a new core dataset, and identifies a number of directions for SAAP data collection efforts, including:

- their extension to include multi-variate modelling
- more information about children requesting services versus those who do not
- better outcome measures relevant to children
- more information about the stability of the population of children in SAAP over time (Norris et al. 2005).

It should be noted that the collection of children's data, including types of services being provided across all SAAP services, was introduced in 2000-01 (the first year of SAAP IV) and that the new core data set varies little from that introduced in 2000-01. There is however a greater attention being paid to children in SAAP especially with regard to how the data can assist with future policy directions for the provision of SAAP services to children (Department of Health and Human Service Tasmania).

However, the researcher's consideration of the form in which the SAAP National Data Collection Agency (NDCA) data are reported back to services shows that these data analyses do not easily suggest how they can provide a point of departure for developing better practices for small children (SAAP National Data Collection Agency 2004).

How should such data be analysed so that it is more useful to practitioners in on-the-ground' services? This is a question that raises necessarily technical issues to do with data analysis.

It is unlikely that multi-variate alone will deliver data analyses in a form that has maximum usefulness for SAAP practitioners. The literature driven by classical experimental research models has not given practitioners confidence about the ‘therapies or modalities’ needed by particular populations. Nor will more multi-variate quantitative approaches by themselves necessarily offer expanding awareness of effective elements in meeting the needs of small children or respond to the need for new transdisciplinary research methods that offer a way forward for a body of research that has often assumed ‘one size fits all’ definitions of clients, services and communities. Even where the existing research and data analyses offer empirical rigour they have generally not examined why one intervention works for one population but not for another, or in one service context but not in another. Accordingly, there is need for future data analysis approaches in domestic violence to go beyond the methods of the ‘variable-oriented researcher’ (Ragin 1997), drawing upon the international body of work associated with ‘Quali-Quantitative Analysis’ (QQA)², a multidisciplinary research movement that began with team member Charles Ragin’s seminal book (Ragin 1987) almost twenty years ago. Quali-Quantitative Analysis have particular value for exploring the multidimensional, configurational nature of clients, services, and their communities. It offers a particularly useful tool for examining the effectiveness of service interventions which bring considerable challenges of understanding causality in small-*N* populations (Ragin and Sonnett Kropp, S. and Minkenberg, M. 2004, Ragin Brady, H. E. and Collier, D. 2004, Ragin 1999, De Meur and Rihoux 2002, Ragin Kelle, U. 1995, Ragin Janoski, T. and Hicks, A. M. 1994). In particular, such a methodology has value for translating configurational organisational theory, emphasising nonlinearity, synergy and equifinality (multiple effective configurations) into approaches to domestic violence services, allowing researchers to move beyond the methodologies of classical empirical research, which often rely upon assumptions of linearity, additive effects, and unifinality (one optimal configuration). (Fiss 2005a). As Fiss’s work suggests (Fiss 2005b), rather than evaluating a particular ‘intervention’ and set of ‘variables’ in a dataset, a QQA approach to analysing the effectiveness of domestic violence interventions for small children would focus upon identifying relationships between service interventions and different sub-groups of clients in different service element combinations (therapeutic as well as operational) in different communities. That is, QQA offers useful information for service designers, policy makers and practitioners, not least because it offers a focus upon describing different client-service-community configurations as possible applications of particular therapeutic approaches used by services. Accordingly, recommendation 10 at the end of this report suggests that the data already collected by SAAP services be developed for use in practitioner-oriented QQA approaches.

What issues of practice in this area were yielded by the interviews with SAAP agencies?

² Also known as ‘Qualitative Comparative Analysis’; the term ‘Quali-Quantitative Analyses’ is more accurate.

Women's IEA SAAP agencies provided quite detailed information about their experiences and views of issues surrounding recording and reporting:

- SAAP agencies are following the standard reporting requirements of the NDCA; SAAP agencies do not appear to routinely use NDCA reports of their data in their daily work; assessment forms and processes, case notes, and case files are the main source of information used by Women's IEA agencies to develop responses to client needs; in part the lack of use of NDCA data reports has to do with the fact that these reports are not available till long after clients have left; Women's IEA agencies also commented on the complexity of the data entry system for NDCA and the difficulties of training staff to use it.
- The client file is held for seven years; it contains standard forms, such as assessment forms, case notes recording daily client contact records, as well as records of formal meetings, and informal notes; Women's IEA agencies record evidence of domestic violence in the CAT tool and other assessment forms, and in case notes, which are also used when making referrals; the client file also includes details of aftercare.
- Accompanying children have their own file in (some) Women's IEA services; these contain detailed notes of the child's progress such as running records of observations and samples of artwork.
- However, it is not true that Women's IEA services rely exclusively on paper-based information sources; some services are using recording programs such as 'Day Book' developed from Microsoft Access.
- Women's IEA services use consent forms that allow them to discuss the client's case with other agencies for the purposes of case management.
- The Child Protection Assessment and Referral Service (CPAFS—DHHS) is contacted in cases of mandatory reporting; this information is also recorded in case notes, as well as Intake and Assessment forms (developed from a standardised form and used for incidents that need to be reported to Child and Family Services) held for 20 years separately from the client file
- Women's IEA services do not necessarily know what has happened to clients who leave under mandatory reporting circumstances, including when such clients return to crisis accommodation, when the assessment process must begin afresh, uninformed by any follow-up information.
- Women's IEA agencies would like to see a reduction of paperwork, for example, streamlining of the CAT form.
- Women's IEA agencies need more short, powerful and tailor-made tools for gathering information that can effectively inform practice.

Recommendations for developing the usefulness of data collection efforts

In consideration of the available information about data collection issues, the researcher recommends:

R10. That data collection analysis of SAAP data include innovative quali-quantitative methods which have particular usefulness for service practitioners such as those developed by Charles Ragin and documented in this report.

R11. That the community agency network referred to in Recommendation 1 of this report also target optimal data collection and data sharing procedures between agencies, subject to legal and ethical requirements.

Staffing

Staffing issues in the literature and in Women's IEA SAAP services

As noted by one leader in the field (McIntosh 2000): 'Early intervention is rare for pre-schoolers and infants not because they are too young, but because it requires specialist skills, sorely lacking in the domestic violence field' (p.12).

The purpose of this section is to identify some key staffing needs in Tasmanian Women's IEA SAAP services.

Professional training in domestic violence is crucial, including in worker and client safety, anti-racist and anti-discriminatory practices (Humphreys 1999). The literature notes that in crisis accommodation centers 'A well-trained full-time child advocate on the staff of each domestic violence agency is a first step in building an organisation responsive to the needs of children', who can;

- coordinate on-site and off-site services for children
- take a key role in linking client families and relevant community services important to meeting the child's needs, for example, schools and child protection services
- take a role in training and supporting other staff in the service to help them better meet the needs of children (Saathoff and Stoffel 1999).

As emphasised throughout this report, the staffing of crisis accommodation in the interests of children is now about relationships with a whole range of professionals and their organisations, for example, it may involve cross-disciplinary training and development of joint protocols (Saathoff and Stoffel 1999). That is, building coordinated community responses to domestic violence involves a broad range of different kinds of staff training:

- new staff and in-service training
- cross training of staff across different agency and sector issues
- training of trainers
- other training activities such as conferences, informal visits to related agencies in other states etc. (Clark et al. 1996).

However, as noted by at least one researcher (Kripke et al. 1998), there are very few studies of the efficacy of training and professional development interventions for *staff themselves*. Yet it seems there is some evidence that even short workshops can have positive results. The just cited study found positive results in knowledge, self-assessed skills, as well as attitudes for a four hour educational workshop on domestic violence training for medical residents, though the results were not sustained over the long-term, indicating the need for continuous training and development in this area (Kripke et al. 1998).

It is also evident in at least one account of best practice in service delivery (Gevers 1999b) that a high quality training environment involves the following elements

- Orientation, including to other services
- Ongoing mentoring of the staff member
- Ongoing training
- External supervision
- Affirmative action to ensure a diverse staff.

Clearly, staff need to be aware of relevant best practice standards (and relevant national courses and competencies) such as those given in national manuals of best practice for working with children exposed to domestic violence. These include, but are necessarily limited to, standards relevant to;

- ensuring the safety of the child
- ensuring the safety of the child
- working with client groups with specific issues
- accessible culturally relevant service standards
- respecting the child's rights
- appropriate coordination with other services

- the quality and effectiveness of services and their staff
- continuous improvement of services (Gevers 1999c, Gevers 1999b).

Staff need to also be aware of the outcomes of the experiences and learning's of relevant professionals, often published in professional publications across the service spectrum, and often including tools for service delivery evaluation as well as links to professional support networks (Partnerships Against Domestic Violence 2000c, Partnerships Against Domestic Violence 2000b, Partnerships Against Domestic Violence 1999). Staff should also participate in conference on domestic violence and/or have access to their proceedings, for example those from national forums (Partnerships Against Domestic Violence 2000a).

Yet staff training should not just be about therapies, but also about the experience of young people, told by them, which can be powerful information for developing client-centred approaches (Commonwealth of Australia 2001).

A recent review of service provision in Tasmania for children (Love 2003) cited throughout this report examined the qualifications of staff in Tasmanian services working with children who had been exposed to domestic violence. It concluded that over-whelmingly the majority of such staff were tertiary trained, identifying at least six professionals with highly developed recent training such as under the Partnerships Against Domestic Violence Program interstate, which can be contacted through the Office for Women (http://ofw.facs.gov.au/womens_safety_agenda/index.htm).

Interviews with staff in Women's IEA SAAP services themselves suggest a number of issues around the matter of staffing:

- The importance not just of having a child support worker, but of ensuring that all staff work as a team; for example, the child support worker sharing information with the case worker;
- The need for more courses specifically offering formal training to staff in this area, including training across the holistic needs of children exposed to domestic violence and training that helps develop networks with other relevant professionals, as well as facilitates appropriate recognition of Women's IEA SAAP staff skills;
- The need for staff with the necessary training, experience and personal qualities suitable for the crisis accommodation environment;
- The fact that not all Women's IEA SAAP services who need a child support worker have one; such needs can be for a worker on a casual basis to meet periodic needs;
- The fact that not all staff working with children in a child support capacity have relevant specialised training though there is a belief that, for example, using art therapy as an intervention for small children does require specialised training;

- That Women's IEA SAAP services are seeing increasingly complex needs in clients, such as mental health needs, including suicide intervention needs, as well as drug and alcohol treatment needs, that require specialised support for mother and child;
- Women's IEA SAAP services rely on ad hoc training in the form of short workshops for the bulk of their professional development in this area;
- Women's IEA SAAP services want and need access to more specialised training, including relevant high quality workshops; this access is also about creating a training culture in Women's IEA SAAP services; [the need for specialised training was also flagged in a 2003 review of Tasmanian services for children who have been exposed to domestic violence (Love 2003) i.e. 'training to a professional level beyond general information sessions on domestic violence and exchange of information between services about issues and trends' (p. 62)].

Recommendations for developing Women's IEA SAAP staffing

Following on from the above, the researcher recommends:

R11. That the community agency network referred to in Recommendation 1 of this report develop a collaborative statewide training plan for all staff in Tasmanian services dealing with small children exposed to domestic violence.

R12. That all staff in Women's IEA SAAP services who work with children exposed to domestic violence receive ongoing training through such bodies as the Partnerships Against Domestic Violence Program interstate, which can be contacted through the Office for Women. (http://ofw.facs.gov.au/womens_safety_agenda/index.htm)

R13. That each Women's IEA SAAP service that deals with small children who may have been exposed to domestic violence receives dedicated funding for a child support worker.

Prevention

Prevention issues in the literature and in Women's IEA SAAP services

The importance of a well-developed preventative focus in social services (early intervention and support) is also noted in the literature, though services may be poorly resourced for it (Humphreys 1999). Unfortunately, the research also shows that some service responses, such as child protection, 'swing from minimisation on the one hand to highly intrusive forms of intervention on the other' (Humphreys 1999).

The importance of prevention as it affects small children has been emphasised in the literature, particularly as it relates to breaking the inter-generational cycle of violence (Wolfe and Jaffe Graham-Bermann, S. and Edleson, J. 2001):

Ensuring that children receive a healthy start, including freedom from emotional, physical, and sexual abuse and the trauma of witnessing violence, is a fundamental step in preventing the intergenerational patterns of family violence, and one that is supported by 15-20 years of research on the causes of such events. (p. 286)

As for many other areas of response to this social problem, prevention requires a multi-agency prevention response (Peckover 2003, Humphreys 1999). It has long been argued that

Tertiary prevention of domestic violence will require health care organisations to incorporate and invest in crisis intervention, emergency hospitalisation for shelter, counselling, support groups, and advocacy, rather than simple identification and referral. Such a comprehensive approach will require changes in medical practice that rival those seen in law and law enforcement practice' (Flitcraft 1993).

As for other types of interventions in this area, prevention interventions are poorly evaluated. However, in America at least, the focus has been on primary prevention in schools, including the use of materials designed by crisis accommodation services for violence-free relationships, with the most comprehensive of these being the Minnesota program targeting curriculum delivery by teachers (Jaffe et al. 1990).

Prevention interventions for children 0-5 have been conceptualised in one analysis of best practice (Wolfe and Jaffe Graham-Bermann, S. and Edleson, J. 2001) as

- Primary prevention: home visits by professionals such as public health nurses and trained paraprofessionals
- Secondary prevention: home visits targeting at risk groups identified through screening tools
- Tertiary prevention: home visits targeting those identified as having been exposed to domestic violence (p. 287).

Interviews with Women's IEA SAAP services offered some information about issues to do with prevention in the Tasmanian community:

- Women's IEA SAAP services do vary in their prevention activities; in some services these are limited, while in others they include seminars across the state for specific organisations that require education support, community conferences, visits to local primary schools to talk with staff, training with the family court; in other services such activities are not possible due to over-commitment;
- Early education and prevention should ideally include schools;
- Material facilities can play a key role in helping Women's IEA SAAP services do more community education;

- Women’s IEA SAAP services staff could do more community education outside the service if this was properly resourced; some see Women’s IEA SAAP services as being ideally placed to do this kind of early intervention and education;
- Women’s IEA SAAP services prevention activities also need to be understood in terms of the work that takes place within the service, for example, through skills-based programs linked to Employment Plus that help parents develop literacy and numeracy and job skills; such prevention activities also include the work of outreach workers who take a prevention role through their work assisting mothers to resettle.

Recommendations for developing prevention activities

In line with the discussion in the preceding section, the researcher recommends

R14. That the community agency network referred to in Recommendation 1 of this report take a strong community education and prevention focus, expressed in a collaborative statewide plan, particularly through the involvement of pre-school and other early education specialists

R15. That Women’s IEA SAAP services receive dedicated funding for community education and prevention activities

Conclusions: key areas for development of Women’s IEA SAAP services towards this framework

Further to the previous discussion, this section documents some of the areas identified in interviews with Women’s IEA SAAP services staff as important to moving practices forward. Most previously provided recommendations already attempt to respond to these matters; a new recommendation is given where the concluding remarks of Women’s IEA SAAP services about key directions have raised new issues not covered by existing recommendations:

- There is a general need for the community, including policy decision-makers, to become more aware of the issues surrounding small children’s exposure to domestic violence; this education should include better recognition of the role Women’s IEA SAAP services play and the skills the staff in intervening to meet the needs of such children and the important ‘window of opportunity’ that crisis accommodation service represent for these children
- There should be dedicated funding for small children within SAAP funding arrangements; while Women’s IEA SAAP services do not have such dedicated funding and while they must meet the needs of sometimes large numbers of small children who have been exposed to domestic violence there will be significant service gaps

- There should be a review of the residence limitation of six weeks in Women’s IEA SAAP service agreements; this limitation is very difficult to achieve in a manner consistent with client well-being;
 - **R16. That the limitation of six weeks be reviewed in a manner that is consistent with examining the issues of quality service delivery documented in this report**
- Critical high priority needs of Women’s IEA SAAP clients such as those relevant to child protection (Child Protection Assessment and Referral Services) are not always acted upon in a timely fashion with sometimes very serious consequences for children;
 - **R17. That the community agency network referred in Recommendation 1 of this report develop strategies for ensuring that critical high priority needs of Women’s IEA SAAP clients are met in a timely fashion, including as they relate to small children**
- Women’s IEA SAAP services need support to develop practices that engage clients, particularly those sub-groups that are most difficult to engage in the community, such as people from particular ethnic and cultural groups and/or people with multiple difficulties experiencing homelessness, domestic violence and mental health issues, and alcohol and substance abuse; such support should also help different community agencies achieve consistent approaches to the needs of these parents and their children.
- The crisis accommodation service culture may itself need development; this culture may still be more focussed upon adults rather than children; such cultural needs should be reflected in the funding of child support workers across the services.
- Crisis accommodation services face complex challenges maintaining their commitment to be advocates for women and children; increasingly these challenges are about managing ever-more complex relationships with other agencies and associated legal and other requirements, including duty of care requirements; this should be reflected in arrangements for Women’s IEA SAAP services, including client stay lengths.
- Some Women’s IEA SAAP services’ greatest need is for a qualified child support worker; all such workers need to work as part of a collective to be effective and any development of Women’s IEA SAAP services must recognise this as a priority.
- Women’s IEA SAAP services want and need better networks of supporting professionals.

- Women’s IEA SAAP services operate in complex legal contexts, including family law contexts, which present particular challenges for ensuring that the perspectives of small children are heard in a broad range of matters from contact arrangements to sexual abuse; for example, the fact that small children are not credible witnesses has and does present challenges for services advocating for their clients, particularly in contexts where the skills of the sector may not be so well-recognised.
 - **R 18. That the community agency network’s plan for statewide collaborative training for all Tasmanian services, referred to in Recommendation 11 of this report, include particular attention to training in legal issues and legal advocacy on behalf of community agencies to ensure their views are represented to government in the development of future legislation; that this work pay particular attention to the development of legislation that best-positions services to respond to the needs of small children exposed to domestic violence.**

References

- Allen, D. (1995) Hermeneutics: philosophical traditions and nursing practice research *Nursing Science Quarterly*, **8**, 174-182
- Angus, J., Evans, S., Lapum, J., Rukholm, E., St Onge, R., Nolan, R. and Michel, I. (2005) "Sneaky disease": the body and health knowledge for people at risk for coronary heart disease in Ontario *Canada Social Science & Medicine*, **60**, 2117-2128
- Ayoub, C. C., Deutsch, R. M. and Maraganore, A. (1999) Emotional distress in children of high-conflict divorce *Family Court Review*, **37**, 297-315
- Bagshaw, D., Chung, D., Couch, M., Lilburn, S. and Wadham, B. 2000 Reshaping Responses to Domestic Violence University of South Australia, Adelaide.
- Bazelon Center for Mental Health Law. 2003 Suspending Disbelief: Moving Beyond Punishment to Promote Effective Interventions for Children with Mental of Emotional Disorders Bazelon Center for Mental Health Law, Washington DC.
- Becker, P. and Eden, F. 1994 Children in Shelters: A Training Manual for Working with Women and Children who have Survived Domestic Violence Southern Areas Women's and Children's Shelter Inc., Adelaide, South Australia.
- Blanchard, A. (1993) Violence in families: the effect on children *Family Matters*, 31-36
- Cantos, A. L., Neidig, P. H. and O'Leary, K. D. (1994) Injuries of women and men in a treatment program for domestic violence *Journal of Family Violence*, **9**, 113-124
- Carlson, B. E. (2000) Children exposed to intimate partner violence: research findings and implications for intervention *Trauma, Violence and Abuse*, **1**, 321-342
- Clark, S. J., Burt, M. R., Schulte, M. M. and Maguire, K. E. 1996 Coordinated Community Responses to Domestic Violence in Six Communities Urban Institute, Washington.
- Clarke, J. (1999) Hermeneutic analysis: a qualitative decision-trail *International Journal of Nursing Studies*, **36**, 363-369
- Commonwealth of Australia. 2001 Young People and Domestic Violence: National Research on Young People's Attitudes To and Experiences of Domestic Violence Commonwealth of Australia, Canberra.
- Commonwealth Task Force on Child Development Health and Wellbeing. 2003 Consultation Paper: Towards the Development of a National Agenda for Early Childhood Commonwealth of Australia, Canberra.
- Daniel, S. (1986) The patient as text: a model of clinical hermeneutics *Theoretical Medicine and Bioethics*, **7**, 195-210
- De Meur, G. and Rihoux, B. (2002) *L'Analyse Qualit-Quantitative Comparee (AQQC-QCA)*, Academia Bruylant, Louvain-La-Neuve
- Department of Family and Community Services. 2004 Review of the Early Intervention Parenting Program and Good Beginnings Prototypes: Volume One: Final Report Commonwealth of Australia, Canberra.
- Department of Health and Human Services. 2003 Our Kids - Action Plan 2004-2007: Working Towards a Wholistic Response for Tasmania's Children Department of Health and Human Services, Tasmania, Hobart.
- Dickens, J. (2002) Book Reviews: The child's world: assessing children in need *Child and Family Social Work*, **7**, 141-146

- DiClemente, C. (1991) In *Motivational Interviewing: Preparing People to Change Addictive Behavior*(Eds, Miller, W. and Rollnick, S.) Guilford Press, New York, pp. 191-201
- Duffy, S. J., McGrath, M. E., Becker, B. M. and Linakis, J. G. (1999) Mothers with histories of domestic violence in a pediatric emergency department *Pediatrics*, **103**, 1007-1013
- Edleson, J. L., 1995, Mothers and Children: Understanding the Links between Woman Battering and Child Abuse, Retrieved: <http://www.mincava.umn.edu/documents/nij/nij.html>
- Ekman, I. and Skott, C., 2004, Developing Clinical Knowledge through a Narrative-Based Method of Interpretation, Retrieved: 26 April 2005, www.sciencedirect.com.ezproxy.library.uq.edu.au/science?_ob
- Ellison, C. G., Bartkowski, J. P. and Anderson, K. L. (1999) Are there religious variations in domestic violence? *Journal of Family Issues*, **20**, 87-113
- el-Sheikh, M. and Cheskes, J. (1995) Background verbal and physical anger: a comparison of children's responses to adult-adult and adult-child arguments *Child Development*, **66**, 446-458
- Fantuzzo, J. W. and Mohr, W. K. (1999) Prevalence and effects of child exposure to domestic violence *The Future of Children*, **9**, 21-32
- Feldman, R. S., Salzinger, S., Rosario, M., Alvarado, L., Caraballo, L. and Hammer, M. (1995) Parent, teacher, and peer ratings of physically abused and nonmaltreated children's behavior *Journal of Abnormal Child Psychology*, **23**, 317-334
- Findlater, J. E. and Kelly, S. (1999) Reframing child safety in Michigan: building collaboration among domestic violence, family preservation, and child protection services *Child Maltreatment*, **4**, 167-174
- Fiss, P. C. 2005a A Set-Theoretic Approach to Organisational Configurations Queen's University, Kingston, Canada. <http://smalln.spri.ucl.ac.be/WPFull.htm>
- Fiss, P. C. 2005b Towards a Set-Theoretic Approach for Studying Organisational Configurations Queen's University, Kingston, Canada.
- Flitcraft, A. (1993) Physicians and domestic violence: challenges for prevention *Health Affairs*, **12**, 154-161
- Frost, M. (1999) Health visitors' perceptions of domestic violence: the private nature of the problem *Journal of Advanced Nursing*, **30**, 589-596
- Gelles, R. J. (1985) Family violence *Annual Review of Sociology*, **11**, 347-367
- Gennetian, L. A. (2003) Welfare policies and domestic abuse among single mothers *Violence Against Women*, **9**, 1171-1190
- Gevers, L. 1999a Evaluating Service Delivery: Handbook for Evaluating Service Delivery for Services Working With Children and Young People Who Have Lived With Domestic Violence Commonwealth of Australia, Canberra.
- Gevers, L. 1999b Models of Service for Working With Children and Young People Who Have Lived With Domestic Violence Commonwealth of Australia, Canberra.
- Gevers, L. 1999c Practice Standards for Working With Children and Young People Who Have Lived With Domestic Violence Commonwealth of Australia, Canberra.
- Hafkin Pleck, E. (2004) *Domestic Tyranny*, University of Illinois Press, Champaign, IL

- Hegarty, K., Hindmarsh, E. D. and Gilles, M. T. (2000) Domestic violence in Australia: definition, prevalence and nature of presentation in clinical practice *MJA*, **173**, 363-367
- Hester, M., Pearson, C. and Harwin, N. (2000) *Making an Impact: Children and Domestic Violence: A Reader*, Jessica Kingsley Publishers, London
- Hick, C. (1999) The art of perception: from the life world to the medical gaze and back again *Medicine, Health Care and Philosophy*, **2**, 129-140
- Horwath, J. (Ed.) (2001) *The Child's World: Assessing Children in Need*, Jessica Kingsley Publishers, London
- Hoyle, C. (2000) *Negotiating Domestic Violence: Police, Criminal Justice and Victims*, Oxford University Press, Oxford
- Hoyle, C. and Sanders, A. (2000) Police response to domestic violence: from victim choice to victim empowerment? *British Journal of Criminology*, **40**, 14-36
- Humphreys, C. (1999) Avoidance and confrontation: social work practice in relation to domestic violence and child abuse *Child and Family Social Work*, **4**, 77-87
- Huth-Bocks, A. C., Levendosky, A. A. and Semel, M. A. (2001) The direct and indirect effects of domestic violence on young children's intellectual functioning *Journal of Family Violence*, **16**, 269-290
- Indermaur, D. 2001 Young Australians and Domestic Violence Australian Institute of Criminology, Canberra.
- Jaffe, P. G., Wolfe, D. A. and Wilson, S. K. (1990) *Children of battered women*, Sage Publications, Thousand Oaks, CA
- Jenkins, S. 2005a Whole of Government Policy Framework for the Early Years The Interagency Policy Coordination Committee: Department of Premier and Cabinet, Hobart, Tasmania.
- Jenkins, S. 2005b Whole of Government Policy Framework for the Early Years: Literature Review and Early Years Programs, Projects and Initiatives Operating in Tasmania The Interagency Policy Coordination Committee: Department of Premier and Cabinet, Hobart, Tasmania.
- Johnson, M. P. and Ferraro, K. J. (2000) Research on domestic violence in the 1990s: making distinctions *Journal of Marriage and the Family*, **62**, 948-963
- Kelly, J. (2000) Children's adjustment in conflicted marriage and divorce: a decade review of research *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 963-973
- Kilpatrick, K. L. and Williams, L. M. (1998) Potential mediators of post-traumatic stress disorder in child witnesses to domestic violence *Child Abuse and Neglect*, **22**, 319-330
- Koenen, K. C., Moffitt, T. E., Caspi, A., Taylor, A. and Purcell, S. (2003) Domestic violence is associated with environmental suppression of IQ in young children *Development and Psychopathology*, **15**, 297-311
- Kolko, D. (1998) In *Violence Against Children in the Family and the Community*(Eds, Trickett, P. and Schellenbach, C.) American Psychological Association, Washington, DC, pp. 213-249
- Kripke, E. N., Steele, G., O'Brien, M. K. and Novack, D. H. (1998) Domestic violence training program for residents *Journal of General Internal Medicine*, **13**, 839-841
- Lemon, N. K. D. (1999) The legal system's response to children exposed to domestic violence *The Future of Children*, **9**, 67-83

- Levendosky, A. A. and Graham-Bermann, S. A. (2001) Parenting in battered women: the effects of domestic violence on women and their children *Journal of Family Violence*, **16**, 171-192
- Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A. and Shapiro, D. L. (2002) Trauma symptoms in preschool-age children exposed to domestic violence *Journal of Interpersonal Violence*, **17**, 150-164
- Lloyd, S. (1997) The effects of domestic violence on women's employment *Law and Policy*, **19**, 139-167
- Love, L. 2003 Service Provision in Tasmania for Children who Witness and/or Experience Domestic Violence SHE (Support, Help and Empowerment), Hobart, Tasmania.
- Lowes, L. and Prowse, M. (2001) Standing outside the interview process? The illusion of objectivity in phenomenological data generation *International Journal of Nursing Studies*, **38**, 471-480
- Marsh, J. C., D'Aunno, T. A. and Smith, B. D. (2000) Increasing access and providing social services to improve drug abuse treatment for women with children *Addiction*, **95**, 1237-1247
- Mayer, L. and Liebschutz, J. (1998) Domestic violence in the pregnant patient: obstetric and behavioral interventions *Obstetrical and Gynecological Survey*, **53**, 627-635
- McAlister Groves, B. (1999) Mental health services for children who witness domestic violence *The Future of Children*, **9**, 122-132
- McCloskey, L. A. and Walker, M. (2000) Posttraumatic stress in children exposed to family violence and single-event trauma *Journal of the American Academy of Child and Adolescent Psychiatry*, **39**, 108-115
- McGee, C. (2000) *Childhood Experiences of Domestic Violence*, Jessica Kingsley Publishers, London
- McIntosh, J. 2000 key note address: Thought in the face of violence: a child's needThe way forward: children, young people and domestic violenceMelbourne, Victoria April
- Mitchell, R. E. and Hodson, C. A. (1983) Coping with domestic violence: social support and psychological health among battered women *American Journal of Community Psychology*, **11**, 629-654
- Moe, A. M. and Bell, M. P. (2004) Abject economics: the effects of battering and violence on women's work and employability *Violence Against Women*, **10**, 29-55
- Moffitt, T. E. and Caspi, A. (1998) Annotation: implications of violence between intimate partners for child psychologists and psychiatrists *Journal of Child Psychology and Psychiatry*, **39**, 137-144
- Norris, K., Thompson, D., Eardley, T. and Hoffman, S. 2005 Children in the Supported Accommodation Assistance program (SAAP): Final Report Social Policy Research Centre, Canberra, Australia.
- Osofsky, J. D. (1999) The impact of violence on children *The Future of Children*, **9**, 33-49
- Parkinson, G. W., Adams, R. C. and Emerling, F. G. (2001) Maternal domestic violence screening in an office-based pediatric practice *Pediatrics*, **108**, 43-51
- Partnerships Against Domestic Violence Commonwealth of Australia, Canberra
- Partnerships Against Domestic Violence (1999) Commonwealth of Australia, Canberra

- Partnerships Against Domestic Violence 2000a Proceedings of The Way Forward: Children, Young People and Domestic Violence
The Way Forward: Children, Young People and Domestic Violence
Melbourne
- Partnerships Against Domestic Violence (2000b) Commonwealth of Australia, Canberra
- Partnerships Against Domestic Violence (2000c) Commonwealth of Australia, Canberra
- Pearson, J., Thoennes, N. and Griswold, E. A. (1999) Child support and domestic violence: the victims speak out *Violence Against Women*, **5**, 427-448
- Peckover, S. (2003) 'I could have just done with a little more help': an analysis of women's help-seeking from health visitors in the context of domestic violence *Health and Social Care in the Community*, **11**, 275-282
- Peled, E. and Davis, D. (1995) *Groupwork with children of battered women: A practitioner's manual*, Sage Publications, Thousand Oaks, CA
- Peled, E. and Edleson, J. (1995) In *Ending the cycle of violence: community response to children of battered women*(Eds, Peled, E., Jaffe, P. and Edleson, J.) Sage Publications, Thousand Oaks, CA, pp. 77-96
- Perry, B. and Azad, I. (1999) Posttraumatic stress disorders in children and adolescents *Current Opinion in Pediatrics*, **11**, 310-316
- Purvin, D. M. (2003) Weaving a tangled safety net: the intergenerational legacy of domestic violence and poverty *Violence Against Women*, **9**, 1263-1277
- Pynoos, R. and Eth, S. (1986) Witness to violence: the child interview *Journal of the American Academy of Child Psychiatry*, **25**, 306-319
- Ragin, C. (1987) *The Comparative Method*, University of California Press, Los Angeles
- Ragin, C. (1997) Turning the tables: How case-oriented research challenges variable-oriented research *Comparative Social Research*, **16**, 27-42
- Ragin, C. and Sonnett, J., 2004, Between complexity and parsimony: limited diversity, counterfactual cases, and comparative analysis, Retrieved: 16 September, 2005, <http://smalln.spri.ucl.ac.be/WPFull.htm>
- Ragin, C. and Zaret, D. (1983) Theory and method in comparative research: two strategies *Social Forces*, **61**, 731-754
- Ragin, C. C. (1994) In *The Comparative Political Economy of the Welfare State*(Eds, Janoski, T. and Hicks, A. M.) Cambridge University Press, Cambridge
- Ragin, C. C. (1995) In *Computer-Aided Qualitative Data Analysis: Theory, Methods and Practice*(Ed, Kelle, U.) SAGE Publications, London
- Ragin, C. C. (1999) Using qualitative comparative analysis to study causal complexity *Health Services Research*, **34**, 1225-1239
- Ragin, C. C. (2004) In *The Sage Encyclopedia of Social Science Research Methods*(Eds, Lewis-Beck, M., Bryman, A. and Futing Liao, T.) Sage Publications, Thousand Oaks, California
- Ragin, C. C. (2004) In *Rethinking Social Inquiry: Diverse Tools, Shared Standards*(Eds, Brady, H. E. and Collier, D.) Rowman and Littleford Publishers Inc, Lanham, Maryland, pp. 123-138
- Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L. and Feder, G. (2002) Should health professionals screen women for domestic violence? Systematic review *BMJ*, **325**, 314-326
- Richardson, J., Coid, J., Petruckevitch, A., Chung, W. S., Moorey, S. and Feder, G. (2002) Identifying domestic violence: cross sectional study in primary care *BMJ*, **324**, 274-279

- Riger, S. and Staggs, S. L. (2004) Welfare reform, domestic violence, and employment *Violence Against Women*, **10**, 961-990
- Romans, S. E., Poore, M. R. and Martin, J. L. (2000) The perpetrators of domestic violence *MJA*, **173**, 484-488
- Rosen, D. (2004) "I just let him have his way": partner violence in the lives of low-income, teenage mothers *Violence Against Women*, **10**, 6-28
- SAAP National Data Collection Agency (2004) Australian Institute of Health and Welfare, Canberra
- Saathoff, A. J. and Stoffel, E. A. (1999) Community-based domestic violence services *The Future of Children*, **9**, 97-110
- Sable, M. R., Libbus, M. K., Huneke, D. and Anger, K. (1999) Domestic violence among AFDC recipients: implications for welfare-to-work programs *AFFILIA*, **14**, 199-216
- Scheringa, M., Zeanah, C., Drell, M. and Larrieu, J. (1995) Two approaches to the diagnosis of post-traumatic stress disorder in infancy and early childhood *Journal of the American Academy of Child and Adolescent Psychiatry*, **34**
- Schornstein, S. L. (1997) *Domestic Violence and Health Care: What Every Professional Needs to Know*, Sage Publications Inc, Thousand Oaks, CA
- Scott, E. K., London, A. S. and Myers, N. A. (2002) Dangerous dependencies: the intersection of welfare reform and domestic violence *Gender and Society*, **16**, 878-897
- Shepard, M. and Pence, E. L. (1999) *Coordinating Community Responses to Domestic Violence: Lessons from Duluth and Beyond*, Sage Publications Inc, Thousand Oaks, CA
- Shepard, M. F., Elliott, B. A., Falk, D. R. and Regal, R. R. (1999) Public health nurses' responses to domestic violence: a report from the enhanced domestic abuse intervention project *Public Health Nursing*, **16**, 359-366
- Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E. and Shakil, A. (1998) HITS: A short domestic violence screening tool for use in a family practice setting *Family Medicine*, **30**, 508-512
- Siegel, R. M., Hill, T. D., Henderson, V. A., Ernst, H. M. and Boat, B. W. (1999) Screening for domestic violence in the community pediatric setting *Pediatrics*, **104**, 874-877
- Smith, J. P. and Williams, J. G. (1992) From abusive household to dating violence *Journal of Family Violence*, **7**, 153-165
- Standing Committee on Social Issues. 2002 Early Child Development: A Co-ordinated Approach: First Report on Early Intervention for Children with Learning Difficulties New South Wales Parliamentary Legislative Council, Sydney.
- Stanley, N. (1997) Domestic violence and child abuse: developing social work practice *Child and Family Social Work*, **2**, 135-145
- Taft, A. (2002) Australian Domestic and Family Violence Clearinghouse, Sydney
- Tolman, R. M. and Raphael, J. (2000) A review of research on welfare and domestic violence *Journal of Social Issues*, **56**, 655-682
- University of New South Wales (2005) In *Australian Domestic & Family Violence Clearinghouse* University of New South Wales, Sydney, NSW, pp. 1-16
- Vostanis, P., Grattan, E. and Cumella, S. (1998) Mental health problems of homeless children and families: longitudinal study *BMJ*, **316**, 899-902

- Vostanis, P., Grattan, E., Cumella, S. and Winchester, C. (1997) Psychosocial functioning of homeless children *Journal of the American Academy of Child and Adolescent Psychiatry*, **36**, 881-889
- Walby, S. and Allen, J. 2004 Domestic Violence, Sexual Assault and Stalking: Finding from the British Crime Survey Home Office Research, Development and Statistics Directorate, London.
- Warshaw, C. (1998) In *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers* Family Violence Prevention Fund, San Francisco, pp. 48-86. <http://endabuse.org/programs/display.php3?DocID=238>
- Wolfe, D. and Jaffe, P. (2001) In *Domestic Violence in the Lives of Children* (Eds, Graham-Bermann, S. and Edleson, J.) American Psychological Association, Washington, DC, pp. 283-298
- Wolfe, D. A., Crooks, C. V., Lee, V., McIntyre-Smith, A. and Jaffe, P. G. (2003) The effects of children's exposure to domestic violence: a meta-analysis and critique *Clinical Child and Family Psychology Review*, **6**, 171-187
- Woodland, J. 2006 Evaluation of the Support Accommodation Assistance Program (SAAP IV) in Tasmania. Department of Health and Human Services, Tasmania Final draft pp. 48-49 and 85.