An Evaluation of the Child Crisis Intervention Project

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1.0 Introduction

Family/whanau violence is a major public health and criminal justice issue in New Zealand (Ministry of Social Development, 2002). It has high rates of recidivism and a cumulative detrimental affect upon the health and longevity of victims (Cargo, Cram, Dixon, et al., 2002). Family/whanau violence includes a broad range of controlling behaviours which typically involve fear, intimidation and emotional deprivation. Due to methodological and data limitations it is difficult to provide an accurate estimate of the level and nature of violence within New Zealand families/whanau (Ministry of Social Development, 2002). However, New Zealand studies of prevalence and incidence, and literature on the nature and effects of family/whanau violence suggest:

- Family/whanau violence is an issue affecting families/whanau from all cultures, classes, backgrounds and socio-economic circumstances;
- Perpetrators of the most severe and lethal cases are predominately male; and
- Victims of the most severe and lethal cases are predominately women and children (Ministry of Social Development, 2002).

Violence in families/whanau seriously compromises children's safety and wellbeing. The effects of violence are extensive and multi-dimensional and can negatively affect children's personal growth and potential. Children witnessing domestic violence of any kind are known to suffer effects that are detrimental to their physical and mental health and wellbeing, and to be at increased risk of suffering physical, sexual and emotional abuse (Drotar, Flannery, Day, Friedman, Creeden, Gartland, McDavid, Tame, McTaggart, 2003; Edleson; 1999, Henderson, 1996). For example, children who witness ongoing violence are more likely to experience: sadness, confusion, anger, guilt, shame and worry; fear for their own and others safety; blame themselves for violence; and have lower self-esteem (Kelly, Anderson & Dawson, 2003; Maker, Kemmelmerier & Patterson, 1998). Witnessing violence in the home can establish a pattern of aggressive behaviour which perpetrates the cycle of abuse (Drotar, et al., 2003). Evidence suggests that boys who have witnessed their fathers abusing their mothers are three times more likely to become abusive and girls who

have witnessed their fathers' abuse of their mothers are twice as likely to become abused in their own intimate relationships (Straus, Gelles, & Steinmetz, 1980).

Given the well-documented intergenerational cycle of violence, it is clear the consequences of domestic violence extend well beyond the abuser and the victim. Evidence suggests that eradicating domestic violence requires that steps be taken to assist children exposed to violence in order to stop the intergenerational cycle (Ministry of Social Development, 2002). There is increasing recognition that programmes for children exposed to family/whanau violence are key to preventing and reducing ongoing domestic violence (Drotar, et al., 2003).

The Te Rito New Zealand Family Violence Prevention Strategy provides a framework for action to address family/whanau violence in New Zealand (Ministry of Social Development, 2002). The vision and guiding principles of the Strategy acknowledge the importance of violence prevention initiatives for children and young people: "the vulnerability of children, in particular, suggests that initiatives aimed at intervening early in children's lives – by educating and supporting their families/whanau and caregivers – are also a priority. It is therefore imperative that children's and young people's needs and interests are given special attention in developing and implementing family/whanau violence prevention initiatives."

Evaluation of violence prevention programmes specifically for children has been limited, but generally positive (Kelly, Anderson & Dawson, 2003). Evaluation of the impact of three Ministry of Justice and Department of Courts programmes for children who had experienced domestic violence found that the programmes met their stated goals of helping children express their feelings about violence, develop strategies for keeping safe and gain better understating of family/whanau changes (Cargo, Cram, Dixon, Widdowson & Adair, 2002). Similarly, an evaluation of six programmes for child victims or witnesses of family/whanau violence indicated positive changes in behaviour, self-esteem, and expression among participants (Maxwell, 2003; Shepherd & Maxwell, 1999). Features of the programmes identified by parents and children as important for successful outcomes included involvement of parents in the

programmes, children's enjoyment, and opportunities to learn about family/whanau violence, particularly safety plans and children not taking responsibility for the violence (Maxwell, 2003). Other evaluation findings have also highlighted the barriers for children in need to access programmes. The availability of programmes varies widely, and there is an absence of programmes for Maori children in some areas (Barwick, Gray & Macky, 2000, cf Kelly et al., 2003).

As part of a wider response to addressing family/whanau violence prevention and intervention, the Crime Prevention Unit sponsored a programme, implemented by the Domestic Violence Centre (DVC) (Auckland), to provide crisis intervention services for child witnesses of family/whanau violence. The Child Crisis Intervention Project (CCIP) involves the provision of a short term crisis intervention service for children who have witnessed violence in their own homes. The objectives of the CCIP are:

- To increase child safety;
- To improve parenting skills;
- To interrupt the cycle of violence; and
- To increase awareness of the impact of violence on child and parent wellbeing.

Given that few crisis intervention programmes have previously been evaluated in New Zealand, an evaluation of this project (funded by Safer Auckland City) will provide new and valuable information about the impact of the intervention on the health and wellbeing of children who have witnessed family/whanau violence.

2.0 Methods

The aim of this evaluation was to assess the implementation, appropriateness and effectiveness of the Child Crisis Intervention Project with the specific intention of identifying the following:

- Opportunities for improving the reach and model of the CCIP;
- The extent to which children who are exposed to family/whanau violence have poor outcomes and exhibit anti-social behaviour (for example, bullying other children, disobedience, social isolation and poor academic performance at school);
- Effects of family/whanau violence on children's safety;
- Changes in children's emotional responses to family/whanau violence (i.e., feelings of guilt and responsibility);
- Changes in mothers' beliefs about the impact of their children's exposure to family/whanau violence;
- Level of uptake of support services by mothers of children who have been exposed to family/whanau violence; and
- Factors that may influence uptake of support services by mothers of children who have been exposed to family/whanau violence.

The evaluation of the CCIP was conducted between June and November 2003, and this limited timeframe should be acknowledged when considering the extent of evaluation activities.

Regular communication between the evaluation team and the DVC ensured that strategic efforts were undertaken to ensure the evaluation framework was as comprehensive as possible. Meetings were initially held with the Executive Director from the DVC and a representative from Safer Auckland City and latterly with the CCIP Co-ordinator, and advocates for the children. After discussions, agreement was reached on evaluation principles and practices, with particular emphasis on how

to improve current practice while maintaining a commitment to avoid potential retraumatisation of the children.

The scope of evaluation activities incorporated: a review of background documentation related to the CCIP; key informant interviews with the Executive Director and the Child Crisis Team Co-ordinator; analysis of client case record files; key informant interviews conducted post- intervention with child advocates; and post-intervention interviews with families/whanau. Ethical approval for this evaluation was received from the University of Auckland Human Subjects Ethics Committee.

2.1 Project development

Relevant background materials and literature were obtained from the DVC and reviewed. In addition, in order to explore the development and initial implementation of the CCIP, two face-to-face key informant interviews were conducted with the DVC Executive Director and CCIP Co-ordinator. The interview schedule explored the development and desired aims of the CCIP. Interview transcripts were reviewed multiple times and a thematic analysis of data was undertaken. Particular pieces of transcript have been selected for presentation because they illustrate broad thematic patterns, or because they are an example of a unique perspective offered by participants. Interview quotes have been retained as close to their original meaning as possible, however extracts have been presented in a format which excludes speech omissions and repetitions, as their inclusion detracts from the readability of the spoken word.

2.2 Case record review

Two pilot questionnaires were initially developed in consultation with the team at the DVC. The questionnaire included questions from both the Paediatric Emotional Distress Scale (PEDS) and the Dimensions of Stressful Events (DOSE) Rating Scale. However, following a meeting with CCIP child advocates it was decided that

the questionnaire would be replaced with a structured record review, as all required information could be obtained from an analysis of case files.

Case records from all families/whanau who received the CCIP from March to November 2003 were reviewed. Criteria for inclusion in the record review were: agreement from families/whanau to participate in the evaluation, and availability of complete records pertaining to each family/whanau were available for review. A total of 10 partial records were excluded from the evaluation. Data from 89 case records were entered into EPI Info Version 6 for statistical analysis using SAS Version 9 in Windows. Frequency tables were generated for all questions on appropriate variables. Unless otherwise stated, percentages are out of the total of 89 families/whanau. In the descriptive analysis conducted, no weighting was used, or tests of significance undertaken.

The findings from the record review are reported in section 3.2 under the following headings:

- Child demographics;
- Demographics of families/whanau;
- Crisis intervention service utilization;
- Assessment of family/whanau violence;
- Impact of intervention on children's behaviour;
- Safety behaviours; and
- Referral to other agencies.

A content analysis of qualitative responses included in record review data was also undertaken.

2.3 Post intervention interviews with advocates

Face-to-face interviews were undertaken with four advocates from the CCIP team including the Co-ordinator, and three child advocates (one Pakeha female; one Samoan female; and one Pakeha male). All advocates had extensive experience working with children. One was a fully qualified child counsellor, one a therapist within a government agency working with children, and another had international experience in specialist child agencies and was completing a doctorate in clinical psychology. The interview schedules focused on the: process of implementation; reach of the intervention; challenges; and potential impact of the CCIP for children and their families/whanau. Interview transcripts were reviewed multiple times and a thematic analysis of data was undertaken. Particular pieces of transcript have been selected for presentation because they illustrate broad thematic patterns, or because they are an example of a unique perspective offered by participants. Interview quotes have been retained as close to their original meaning as possible, however extracts have been presented in a format which excludes speech omissions and repetitions, as their inclusion detracts from the readability of the spoken word. The findings from these interviews are reported in section 3.3.

2.4 Post intervention interviews with families/whanau

A sub-sample of clients from the case record review were selected for follow-up interviews. Criteria for selection included: current address known to the DVC, and a minimum one month gap between interview and completion of the final CCIP advocate's visit. The range of participants included for follow-up interview was representative of the entire case study review population.

Face-to-face interviews with 16 children and their mothers from nine families/whanau were undertaken by two child advocates from the CCIP team. The advocates who undertook the interviews were responsible for the majority of cases in the CCIP. Interviews occurred one to three months after completion of the CCIP services. The interview schedule focused on: changes in the physical and emotional behaviour of

the children exposed to family/whanau violence within the home setting; recall and utilization of the safety plan; access and uptake of support services; and overall benefits of the CCIP. In partial recognition of their time and contribution, each family/whanau received gift vouchers to the value of $30.00.

In order to ascertain client satisfaction with the CCIP, a further eight telephone interviews were undertaken with women whose children had been visited by child advocates. To encourage frank disclosure of relevant issues, all interviews were undertaken by a member of the IPRC evaluation team and confidentiality was assured. Potential participants were randomly selected from the case record review population. Criteria for exclusion were: participation in the earlier face-to-face interview with advocates, and no known contact details. The interview schedule focused on: perceptions of the advocates and delivery of the CCIP; value of the CCIP; impact of the CCIP on children's safety and wellbeing; uptake of referral services; and any other information considered useful to improving the CCIP service. In partial recognition of their time and contribution, each family/whanau received gift vouchers to the value of $30.00.

All interview transcripts from both the face-to-face and telephone interviews were reviewed multiple times and a thematic analysis of data was undertaken. Particular pieces of transcript have been selected for presentation because they illustrate broad thematic patterns, or because they are an example of a unique perspective offered by participants. Interview quotes have been retained as close to their original meaning as possible, however extracts have been presented in a format which excludes speech omissions and repetitions, as their inclusion detracts from the readability of the spoken word. The findings from these interviews are reported in section 3.4.

3.0 Findings

3.1 Project development

At an organizational level rationale for the establishment of a crisis intervention for children who witnessed family/whanau violence was a desire by the DVC to provide a holistic service specifically by "building a crisis service for children that fitted in with our other adult work" (Executive Director). Prior to the establishment of the CCIP, the DVC provided two clients: a 24 hour crisis telephone line; a callout advocacy service focusing on empowering women to regain control of their lives; a casework team who provide ongoing support for victims of family/whanau violence; and a 'Men's Stopping Violence Programme', an education programme for men who use violence against women.

> "To me it was an opportunity to provide a more holistic comprehensive service to entire families. We are working with violent men, and we work with adult victims and it had a number of different benefits" (Executive Director).

Informed by the experience of attending an international conference focused on intervention opportunities for child witnesses of family/whanau violence, the Executive Director of the DVC investigated similar opportunities for New Zealand. A key finding from the conference was that women often stay in violent relationships because they are unaware of the impact of witnessing violence on the health and wellbeing of their children.

An environmental scan was undertaken by the DVC to establish existing services in New Zealand for child witnesses of family/whanau violence. Findings indicated that the majority of programmes for children were implemented by community agencies, and were dependent on a parent or caregiver taking children to the agencies that provided the service. However, the uptake of these services was low, and it was considered important to address this gap.

> "We all knew that the uptake for children's programmes was really low to the point where a lot of children's programmes were falling over despite the fact that funding was available. People just didn't apply or seem to get there and as an agency we had thought for a long time that we needed to provide a

> better response for children who were affected by violence. I really felt in terms of the development of the agency that's what we had to be dealing with, we had to address that issue of the children who had witnessed violence because no-one else was picking that up and it was a gap. Children who had not been assaulted themselves and where there is no perceived danger to them of a physical nature" (Executive Director).

While the DVC was primarily responsible for the development of the CCIP, intersectoral support and collaboration was sought from a wide range of professionals working with children including child therapists, psychologists and social workers. As part of the environmental scan, international programmes were investigated and where practical, "we combined this with our own knowledge, based on our many years of work with families struggling with violence in the home" (Executive Director).

Programme development incorporated existing DVC resources and expertise:

> "[there was a] lot of material lying around that was useful to put together frameworks for reports like risk assessment which I based on material from overseas. Lots and lots of research material that was useful for training potential staff" (Executive Director).

Information related to child witnesses of family/whanau violence is referred to the DVC via the Police incident report sheet (POL400), which is then internally referred to the Child Crisis Team. Initially, the CCIP was designed to operate over a series of three visits between the family/whanau and the advocates, including: a risk assessment, safety plan; assistance with parenting problems; brief crisis therapy for the children; and (where appropriate) referrals to other services in the community.

However, it was determined that another advocate was also required to support primary caregivers/mothers.

> "We quickly found that it was essential to send a women's advocate on the first visit as well. Mothers had so many questions and were so desperate to talk about their children and also the amount of information we required of them, meant that on the first visit the advocate was tied up just talking with them. Now both advocates make the first visit in pairs, which frees up the child advocate to concentrate on the children" (Executive Director).

The timing of the three visits is negotiated between the advocates and each family/whanau. However, it is intended that the CCIP operate over a three week time span, with a visit occurring each week. At the time of arranging visits, advocates are required to establish whether the offender is still residing in the home and if the offender is likely to be present at the time of the visit:

> "Advocates always have contact with the family before they go out - they never go out cold. It's up to them to find out does he (the offender) live at home, is he at home during the day. Also, I can see from the POL 400 if the offender lives there and I usually let the advocates know that to. The other safety thing that they normally do is they always ring before they leave home just in case circumstances have changed in case he has come back home. They don't check in with us when they've finished. We've never had any safety issues. I guess we know that when you are working with offenders of family violence they are really most harmful to their families not to anyone else" (Co-ordinator).

The selection of appropriate personnel was identified as an important issue for the CCIP. Interviewing, employing, training and co-ordination of the CCIP team is carried out by the Co-ordinator.

> "I interview new advocates. We have 11 child advocates and seven women's advocates. Then I co-ordinate and organise advocates to go out and then to continue to co-ordinate the advocates through the three visits in practise issues. Then I do training with the advocates with one of the senior advocates. I do a lot of debriefing if they have a [difficult] case" (Co-ordinator)

There are 11 child advocates and seven women's advocates in the CCIP team. The role of the Co-ordinator is "to receive all the referrals and assess them and decide whether they meet the criteria and then to contact the family/whanau and tell them about the service and try and arrange the uptake of the service." The Co-ordinator is also responsible for co-ordinating and organising the advocates to undertake the three visits to the families/whanau. With a fellow senior advocate, the Co-ordinator is involved in the interviewing, selection and training of advocates. The DVC acknowledge the challenges associated with responding appropriately to family/whanau violence in a range of cultural contexts. The majority of advocates are Pakeha women, one Maori woman, two Asian women and one Pacific Island women. Three advocates are Pakeha men.

Acknowledging the sensitive nature of family/whanau violence prevention, the DVC also recognized that supervision of advocates is important. While advocates provide their own practice supervision, peer support and supervision is available from the DVC: “They get their own practice supervision and then we have peer supervision every other month. I have supervision once a month” (Co-ordinator). In addition, a number of the advocates contact the Co-ordinator for informal telephone debriefings.

Reflecting on measures of success for the CCIP, the DVC Executive Director first considered that an initial sign of success would be the uptake of appropriate support services by the families/whanau and documented evidence to indicate that children’s “somatic symptoms and also behaviour responses are being modified.” Further signs of success would be if established safety plans are remembered and understood by the children, and utilised by children if the violence continues in their homes. Finally, success would be further indicated by changes in mother’s awareness of the effects of family/whanau violence on their children’s health and wellbeing.

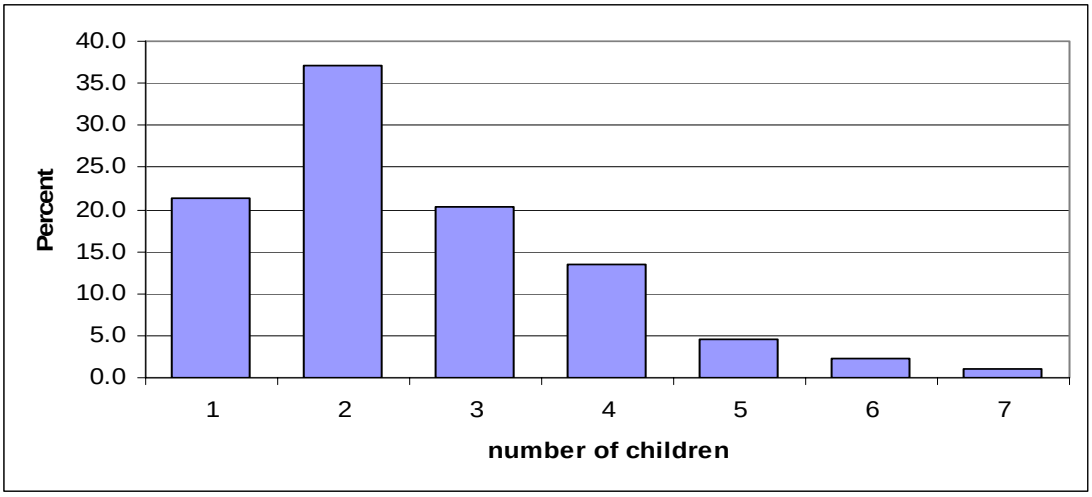
> “We see women who are getting stronger and when we talk to them about their children and what we can see the effects are, we can see that there are realisations that go on. Even if immediately they don’t say we are going to leave tomorrow, I think that we are definitely getting them towards the point where they will” (Co-ordinator).

3.2 Case record reviews

Child demographics

An analysis of case files of those family/whanau who received the CCIP services indicated contact with a total of 226 children in 89 families/whanau with an average of 2.5 children per family/whanau. The total number of children in each family/whanau ranged from one to seven. Figure One shows that most families/whanau (n=33; 37.1%) had two children in the family/whanau, followed by 19 (21.3%) with one child, and 18 (20.2%) clients had a total of three children in the family/whanau. One family/whanau had seven children in the family/whanau.

Figure 1: Total number of children in family/whanau



Gender:

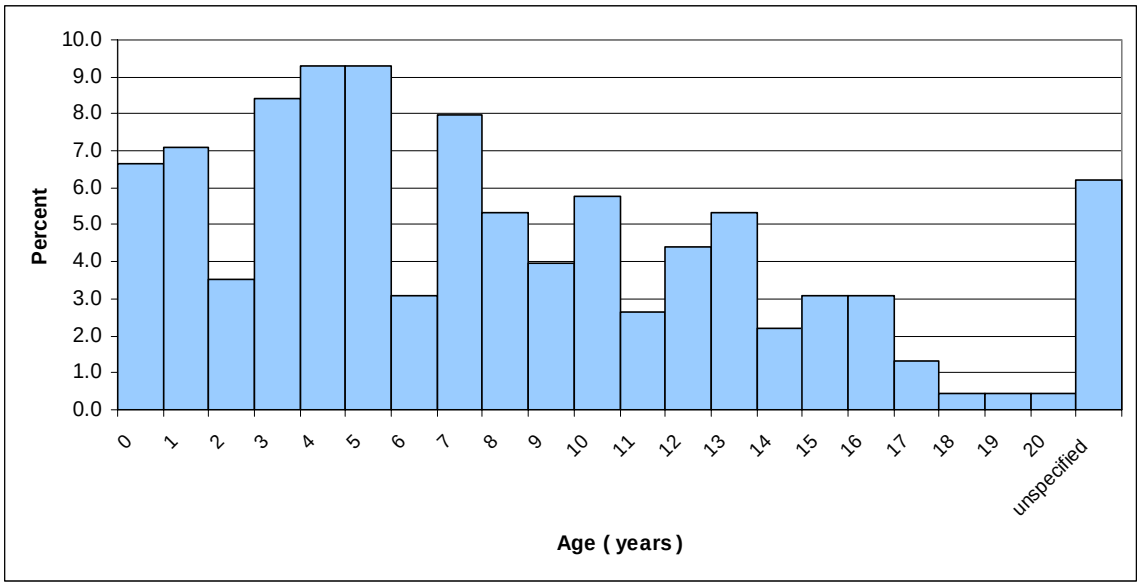
Nearly half of the children (n=111; 49.1%) were male; 104 (46.0%) were female; and files relating to 11 (4.9%) did not specify their gender.

Age:

Figure Two shows that the age range of the 226 children in the 89 families/whanau was under one to 20 years. Most of the children were aged four (n=21; 9.3%) and five years (n=21; 9.3%), followed by three years (n=19; 8.4%), and seven years

(n=18; 8.0%). The age of the children was centred with a mean of seven years and median of six years.

Figure 2: Age of children in the families/whanau of clients



Ethnicity of primary carer/mother:

Table One shows that nearly one-third (32.6%) of primary child carers/mothers self identified as New Zealand European/Pakeha. The second largest ethnic group self identified as Pacific (30.3%), followed by 21.4% who self-identified as Maori, and 12.4% who self identified as Asian. Two files (2.3%) did not record the ethnic group of the primary child carer/mother.

Table 1: Mother's ethnicity

Ethnicity	Frequency	Percent
NZ European	29	32.6
Pacific	27	30.3
Maori	19	21.4
Asian	11	12.4
Other	1	1.1
Unknown	2	2.3
Total	**89**	**100.0**

Most of the children (n=159; 70.4%) were interviewed by the child advocate as part of the CCIP. However, over a quarter (n=61; 27.0%) of children had not been interviewed by a children's advocate. These children were significantly ($p<0.001$) more likely to be aged two and under (n=33; 54.1%) compared to those aged three and above (n=24; 39.3%).

Only three (1.3%) children aged over two years refused to be interviewed by a child advocate as part of the CCIP. Of these children, two females aged 12 years and 14 years were from the same family/whanau and the rationale for refusal was not provided. Another refusal (female aged 15 years) stated she was "sick of the whole situation."

Demographics of families/whanau

Most of the families/whanau (n=68; 74.6%) who received the CCIP had been resident in Auckland for the previous 12 months; 12 (13.5%) were recent migrants to New Zealand; and three (3.4%) had recently moved to Auckland from elsewhere in New Zealand. There was no information on residency provided for six families/whanau (6.7%).

The 89 families/whanau came from a total of 31 different suburbs: Mt Roskill (n=12; 13.5%); Glen Innes (n=11; 12.4%); Avondale (n=8; 9.0%); Onehunga (n=8; 9.0%); Mt Wellington (n=6; 6.7%); Sandringham (n=5; 5.6%); Remuera (n=4; 4.5%); Waterview (n=4; 4.5%); Balmoral (n=3; 3.4%), and New Windsor (n=3; 3.4%). Two (2.3%) families/whanau came from each of the following suburbs: Ellerslie, Hillsborough, Mt Albert, and Panmure. One family/whanau came from each of the following suburbs: Blockhouse Bay; Penrose; Te Papapa; Orakei; Parnell; St Heliers; St Johns; Grey Lynn; Ponsonby, Western Springs; Glenfield; Mairangi Bay; Milford; Henderson; New Lynn; Epsom; and Mt Eden. In Table Two, suburbs that were close to each other were grouped under the same category.

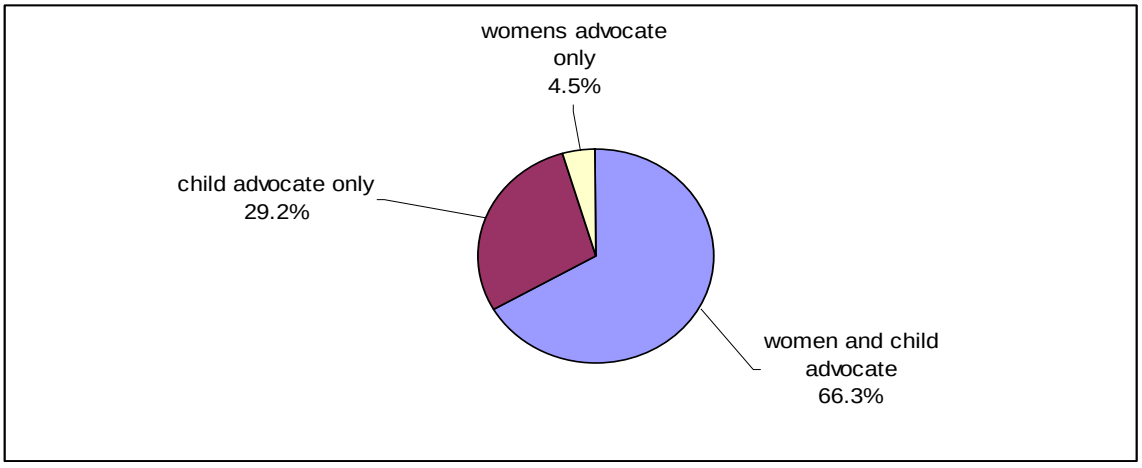
Table 2: Suburb where the families/whanau reside

Suburb	Frequency	Percent
Glen Innes / Mt Wellington / Ellerslie / Panmure	21	23.6
Mt Roskill / Mt Albert / New Windsor	17	19.1
Avondale / Waterview / Blockhouse Bay / Hillsborough	15	16.9
Onehunga / Penrose / Te Papapa	10	11.2
Sandringham / Balmoral	8	9.0
Remuera / Orakei / Parnell / St Heliers / St Johns	8	9.0
Grey Lynn / Ponsonby / Western Springs	3	3.4
Glenfield / Mairangi Bay / Milford	3	3.4
Henderson / New Lynn	2	2.2
Epsom / Mt Eden	2	2.2
Total	**89**	**100.0**

Crisis intervention service utilisation

Sixty-six percent (n=59) of the families/whanau who received the CCIP services were visited by both a woman's and child's advocate from the DVC. Over one-quarter (n=26; 29.2%) were contacted by children's advocates only; and four (4.5%) were contacted by women's advocates only (see Figure Three).

Figure 3: DVC services provided



Women's and children's advocates:

Of the 59 families/whanau who were seen by woman's and child's advocates, 58 families/whanau received one woman's advocate visit, with one family/whanau receiving two visits from the woman's advocate. In addition to the visit from the woman's advocate, most families/whanau (n=53; 89.8%) received three child advocate visits; five (8.5%) families/whanau received one child advocate visit; and one family/whanau (1.7%) received two child advocates visits.

Nearly two-thirds (n=38; 64.4%) of initial women's advocates visit with the family/whanau occurred in the same month that the DVC received the POL400 forms; and 36 (61.0%) of the initial children's-advocates visit with the family/whanau were in the same month. Eight families/whanau (13.6%) received their first women's advocate visit one month after the DVC received the POL400 forms; one (1.7%) was after three months; one (1.7%) was after four months; and one (1.7%) was after eight months. Similarly, 10 families/whanau (17.0%) had their first children's advocate visit one month after the DVC received the POL400 forms; one (1.7%) was after three months; one (1.7%) was after four months; and one (1.7%) was after eight months.

Children's advocate only:

Twenty-six families/whanau received a visit from a child advocate. Twenty-three of these families/whanau received a second visit and 20 received a third visit. Most child advocates' initial visit with the family/whanau occurred within one month of receipt of the POL400 forms (n=17; 65.4%) by the DVC. Nearly one-quarter of child advocates visits (n=6; 23.1%) occurred within two months of receipt of the POL400 forms; two (7.7%) occurred between two-to-three months; and one (3.9%) was after four months.

Women's advocate only:

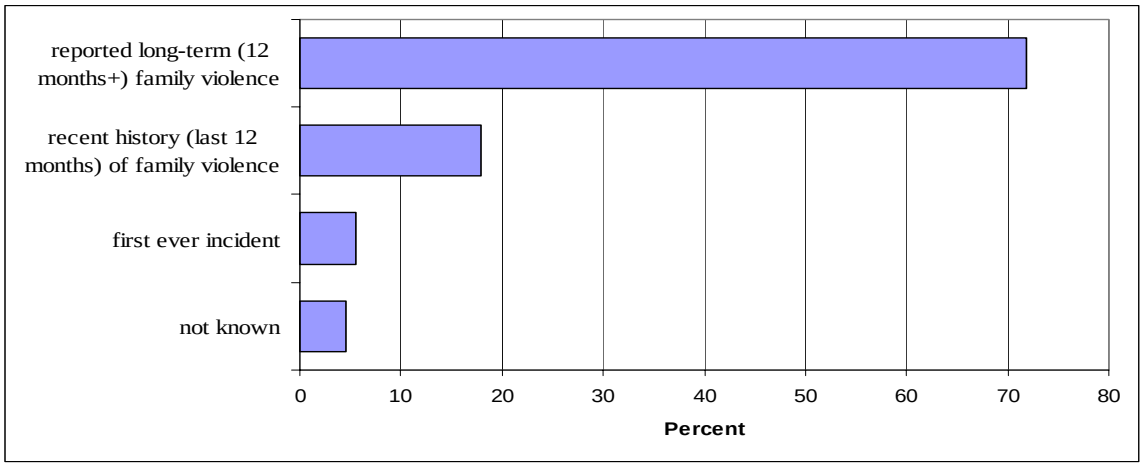
Of the four families/whanau who were seen by women's advocates only, one family/whanau (25.0%) received three visits with a woman's advocate; the others received one visit (n=3; 75.0%). Two families/whanau received their first visit from a

woman's advocate within one month of DVC receipt of the POL400 forms; and one family/whanau did not receive a woman's advocate visit until three months after the POL400 form had been received by the DVC.

Assessment of family/whanau violence

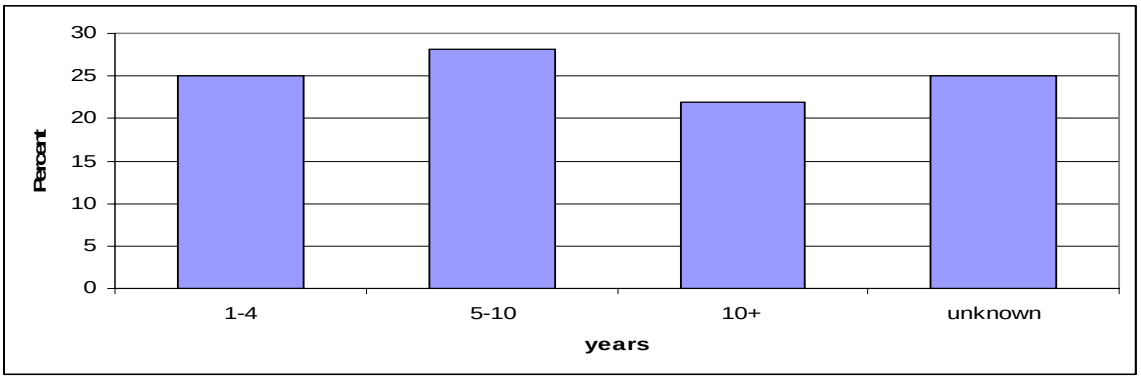
As shown in Figure four, violence within the family/whanau was reported as long-term (more than 12 months) (n=64; 71.9%); 16 (18.0%) families/whanau showed a recent history (occurring only during the 12 months) of family/whanau violence; five (5.6%) families/whanau reported that this was the first-ever incident; and four (4.5%) cases were unknown.

Figure 4: Time span for family/whanau violence



Of the 64 families/whanau who reported experiencing long-term family/whanau violence, Figure Five shows that over one-quarter (n=18; 28.1%) of these families/whanau had experienced family/whanau violence over an estimated time span of between five and ten years. One quarter of families/whanau (n=16; 25.0%) had experienced family/whanau violence over a one to four year time span; and 14 (21.9%) families/whanau reported family/whanau violence occurring for at least 10 years. Information was not available for 16 (25.0%) of the families/whanau.

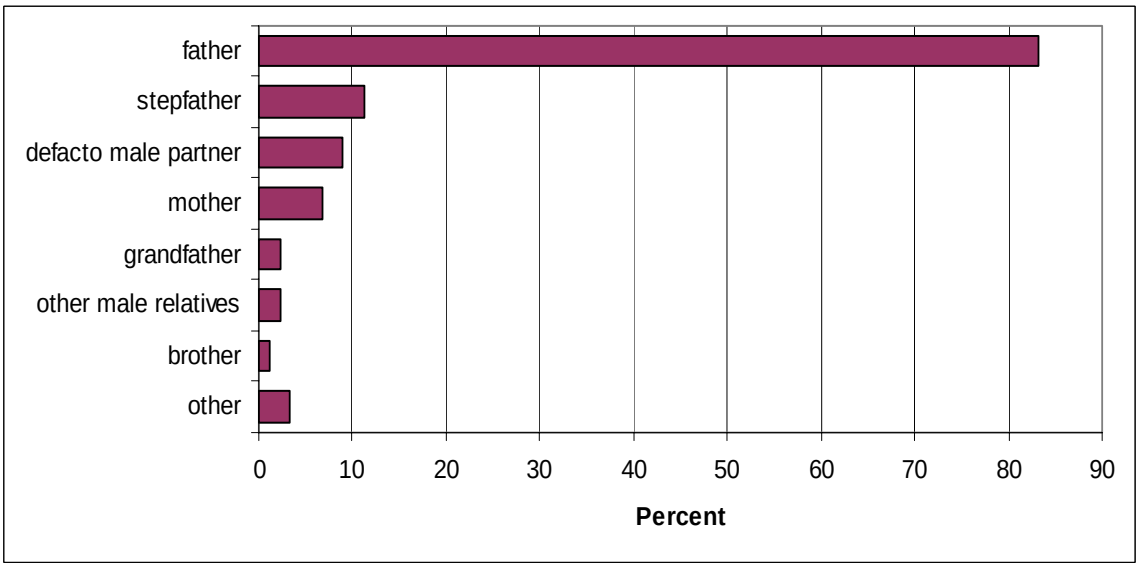
Figure 5: Estimated time span of long-term (12 months+) family/whanau violence



Primary perpetrator of family/whanau violence:

Figure Six shows that the primary perpetrator of the family/whanau violence was the biological father of the children exposed to family/whanau violence (n=74; 83.2%). Other primary perpetrators of family/whanau violence included: stepfather (n=10; 11.2%); defacto male partner (n=8; 9.0%); mother (n=6; 6.7%); grandfather (n=2; 2.3%); other male relatives (n=2; 2.3%); brother (n=1; 1.1%); and others (n=3; 3.4%) which included the children's maternal aunt, partner's ex-wife and other family/whanau members.

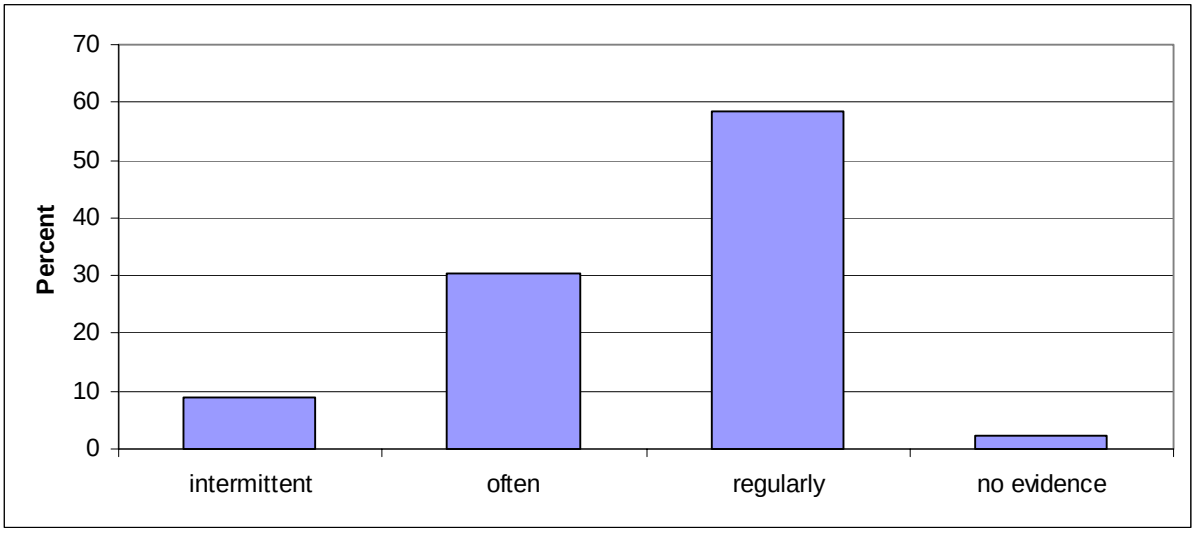
Figure 6: Primary perpetrator of violence



Children's exposure to psychological violence:

Figure Seven shows that in over half of the families/whanau (n=52; 58.4%) children were reported to have been exposed to psychological violence such as yelling and/or arguing between adults on a regular basis. In 27 families/whanau (30.3%) children were reported to have been exposed to psychological violence often.

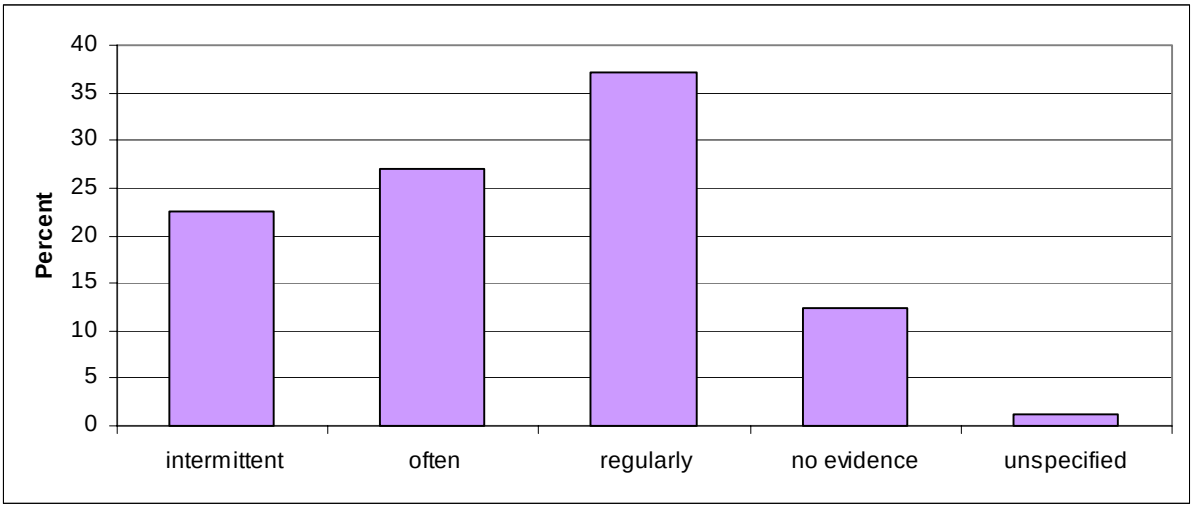
Figure 7: Children's exposure to psychological violence



Children's exposure to physical violence:

As shown in Figure Eight, in over one-third of families/whanau (n=33; 37.1%), children were reported to have been exposed to physical violence, for example, witnessing hitting between adults on a regular basis. In over one-quarter of the families/whanau (n=24; 27.0%), children were reported to have been exposed to physical violence often; and 20 (22.5%) were intermittently exposed to physical violence.

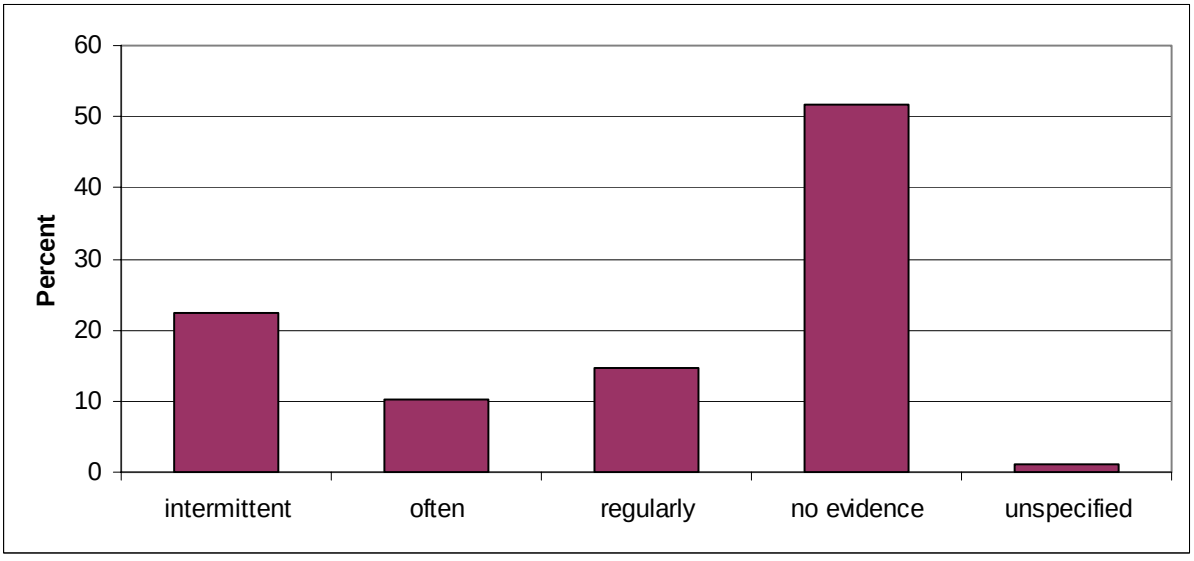
Figure 8: Children's exposure to physical violence



Children's experience of physical violence:

In over one-fifth of families/whanau (n=20; 22.5%), children were reported to have experienced physical violence, such as being hit, intermittently. In 13 families/whanau (14.6%), children reported experiencing physical violence on a regular basis. For over half of the families/whanau (n=46; 51.7%) there was no evidence that the children had experienced physical violence (see Figure Nine).

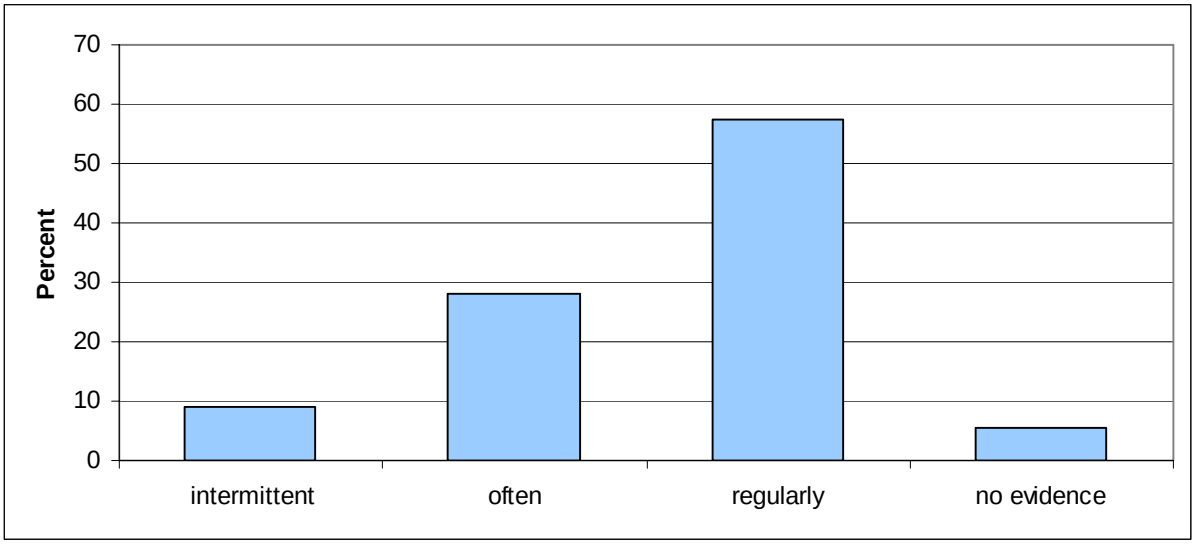
Figure 9: Experienced physical violence



Children's experience to psychological violence:

As shown in Figure 10, in over half of the families/whanau (n=51; 57.3%), children were reported to have experienced psychological violence such as being emotionally abused on a regular basis; and in 25 (28.1%) of the families/whanau, children were reported to have experienced psychological violence often.

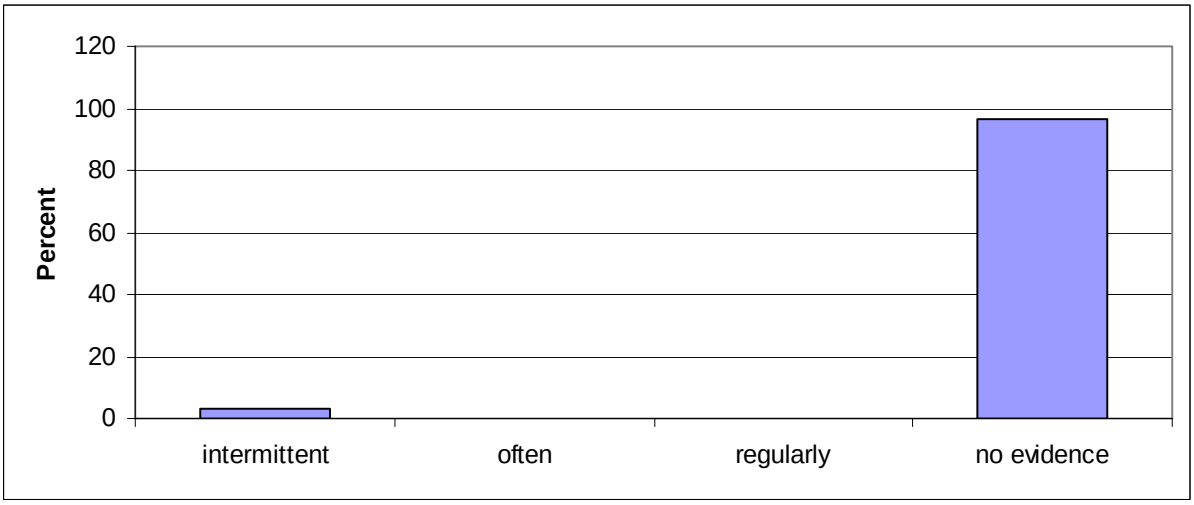
Figure 10: Experienced psychological violence



Children's experience to sexual abuse:

Data from three families/whanau (3.4%) provided evidence of children's experiences of intermittent sexual abuse (see Figure 11).

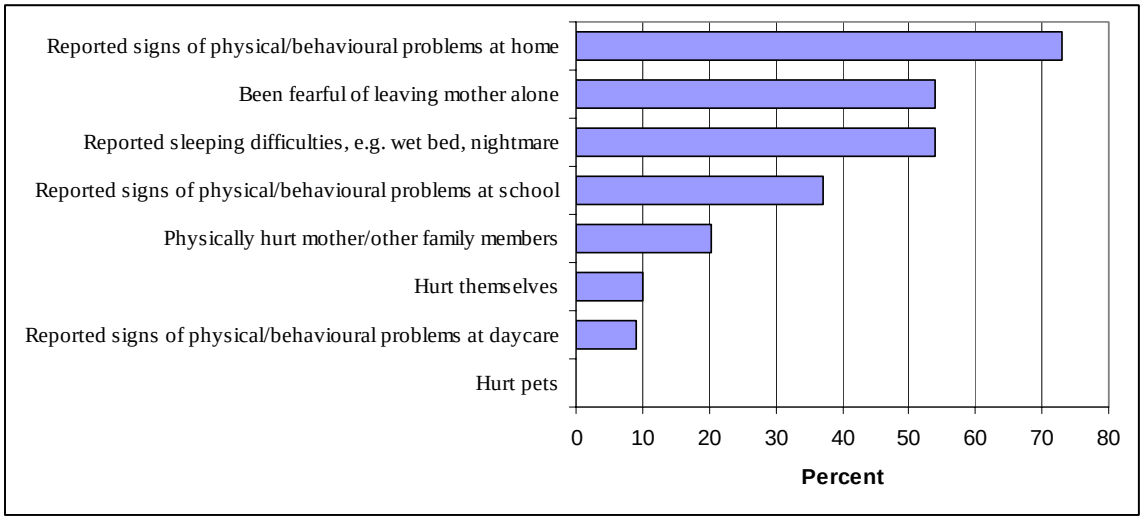
Figure 11: Experienced sexual abuse



Impact of domestic violence on children's wellbeing

Figure 12 shows that most of the 89 families/whanau reported signs of physical and behavioural problems with their children at home (n=65; 73.0%). In over half of families/whanau, children were fearful of leaving their mother alone (n=48; 53.9%); and sleeping difficulties were reported, for example, bed wetting and nightmares (n=48; 53.9%). Over one-third of families/whanau (n=33; 37.1%) reported signs of physical and behavioural problems with their children at school. In 18 (20.2%) families/whanau, children had physically hurt their mother or other family/whanau members; in nine (10.1%) families/whanau, children had hurt themselves; and in eight (9.0%) families/whanau, there were reported signs of physical and behavioural problems with children at daycare.

Figure 12: Reported physical and behavioural problems



Impact of CCIP on children's wellbeing

Children from 73 (82.0%) families received three visits from a child advocate. Of these families/whanau, statements in the advocates' reports indicated a positive change in children's wellbeing over the period of the advocates' visits (n=31; 42.5%). Just under one-quarter (n=18; 24.7%) indicated no change in children's wellbeing; and data were not available for the remainder of this sample (n=24; 32.9%).

Table Three shows that nearly three-quarters of the 73 families/whanau (n=54; 74.0%) reported signs of children displaying physical and behavioural problems at home at the time of the first advocates' visit. Of these families/whanau, five (9.3%) families/whanau reported a positive change in their children's behaviour by the third visit. Forty-five (62%) 73 families/whanau reported sleeping difficulties such as bed wetting or nightmares at the first advocate's visit, with 10 (22.2%) families/whanau reported positive change by the third visit. In over half of the families/whanau (n=42; 57.5%) children were fearful to leave their mother alone at the time of the first visit, with four (9.5%) of families/whanau reporting positive change in children's behaviour by the third visit.

Table Three also shows that at the time of the first visit from the advocates 30 (41.1%) of the families/whanau had reported signs of children displaying physical and behavioural problems at school; four (13.3%) families/whanau reported positive change in their children's behaviour by the third visit. At the time of the first visit, just over one-fifth (n=16; 21.9%) of families/whanau reported that their children had physically hurt their mother or other family/whanau members; one family/whanau (6.3%) reported a positive change by the third visit. At the time of the first advocate's visit eight (11.0%) families/whanau reported that their children had hurt themselves; two of these families/whanau (25.0%) reported a positive change in their children's behaviour by the third visit. Six (8.2%) families/whanau reported that their children had physical and behavioural problems at daycare. No change in the children was reported from these families/whanau by the third visit.

Table 3: Impact of advocate visits

Events	**Number (%)**	
	Families'/whanau reported experience of first visit *(% out of 73)*	**Positive change at third visit**
Physical/behavioural problems at home	54 (74.0)	5 (9.3)
Reported sleeping difficulties, e.g. wet bed, nightmare	45 (61.6)	10 (22.2)
Been fearful of leaving mother alone	42 (57.5)	4 (9.5)
Physical/behavioural problems at school	30 (41.1)	4 (13.3)
Physically hurt mother/other family/whanau members	16 (21.9)	1 (6.3)
Hurt themselves	8 (11.0)	2 (25.0)
Physical/behavioural problems at daycare	6 (8.2)	0 (0.0)
Hurt pets	0 (0.0)	0 (0.0)

Safety behaviours

Pre-intervention:

Records indicated that when physical or verbal violence occurred in the home, most children (n=40; 44.9%) spontaneously stayed with their mother; 37 (41.6%) left the room; 27 (30.3%) asked adults to stop fighting. One-fifth (n=15; 16.9%) of the children hid themselves; 14 (15.7%) left the house; and 14 (15.7%) reported other actions including going to their bedroom; locking themselves into a bathroom; being locked into a room by their mother; going to grandparents; and removing themselves and other younger siblings from the room in which the violence was occurring (see Figure 13).

Figure 13: ***What do child/ren report spontaneously doing, when adults in the house are physically or verbally violent?***

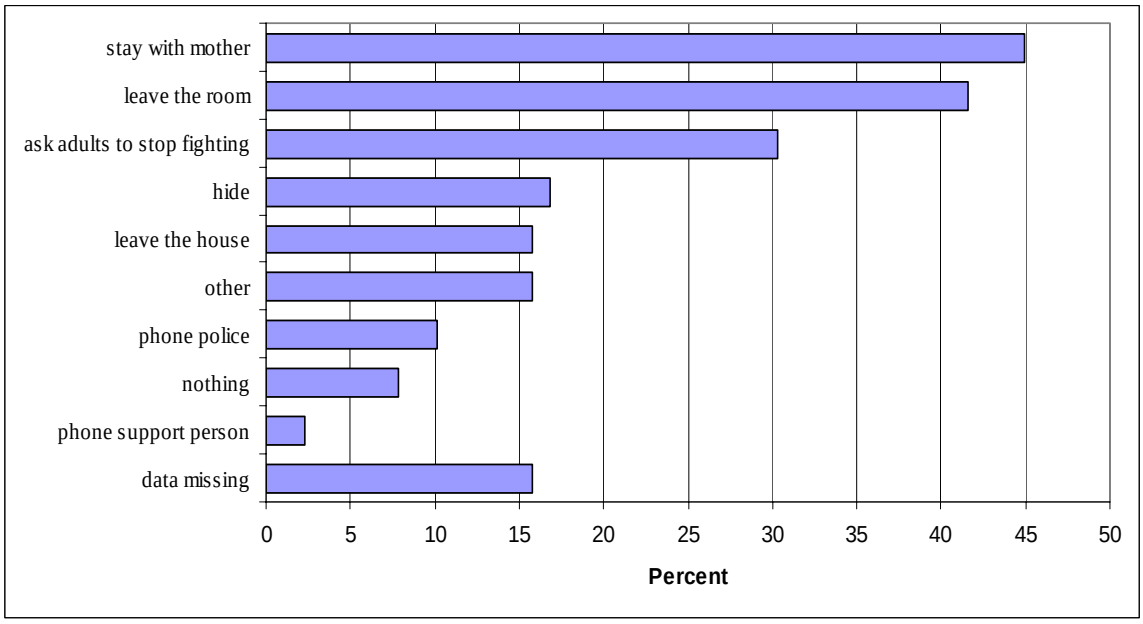
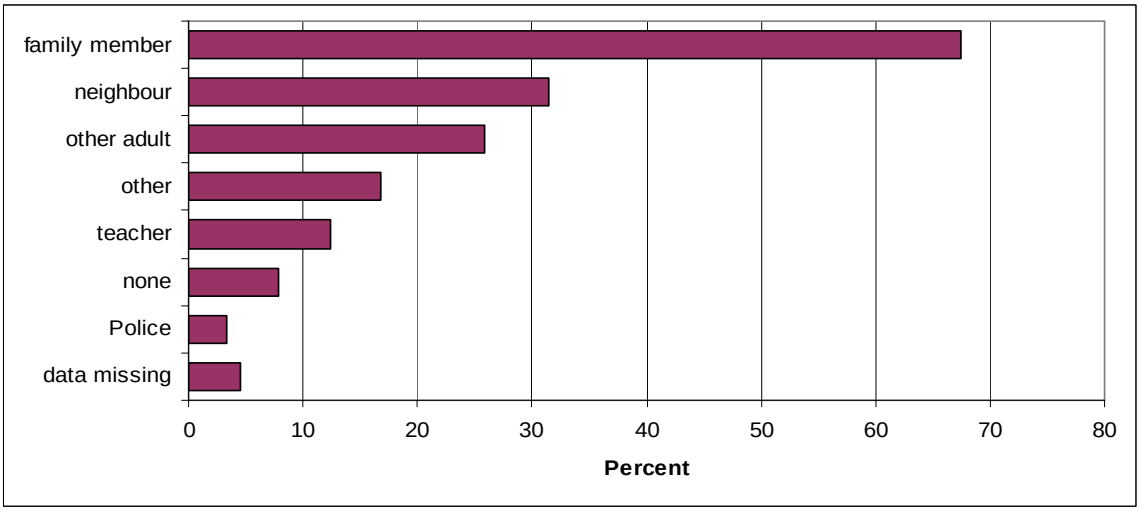


Figure 14 shows that in most families/whanau children accessed a family/whanau member for support when there was an incident of family/whanau violence (n=60; 67.4%). In nearly one-third of the families/whanau (n=28; 31.5%), children contacted a neighbour as a support person.

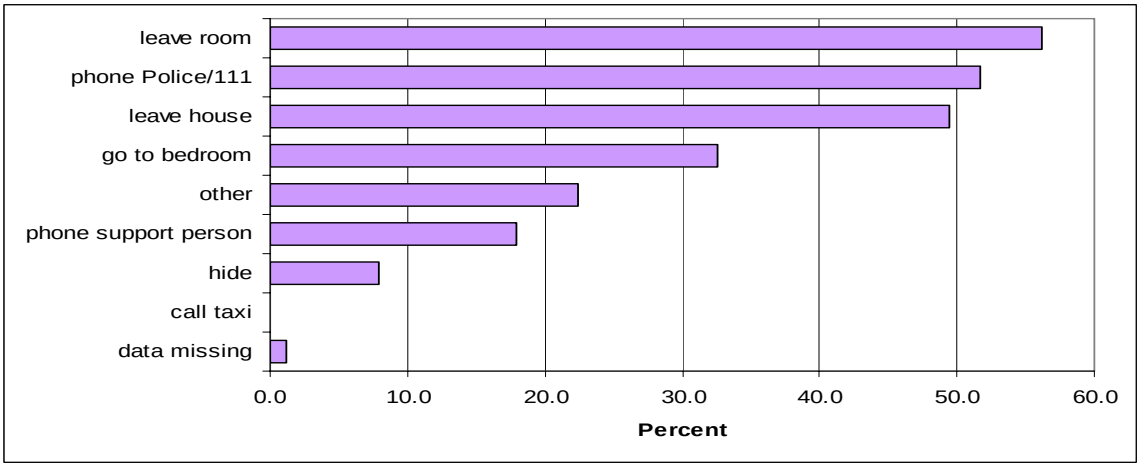
Figure 14: Support people contacted



Post-Intervention:

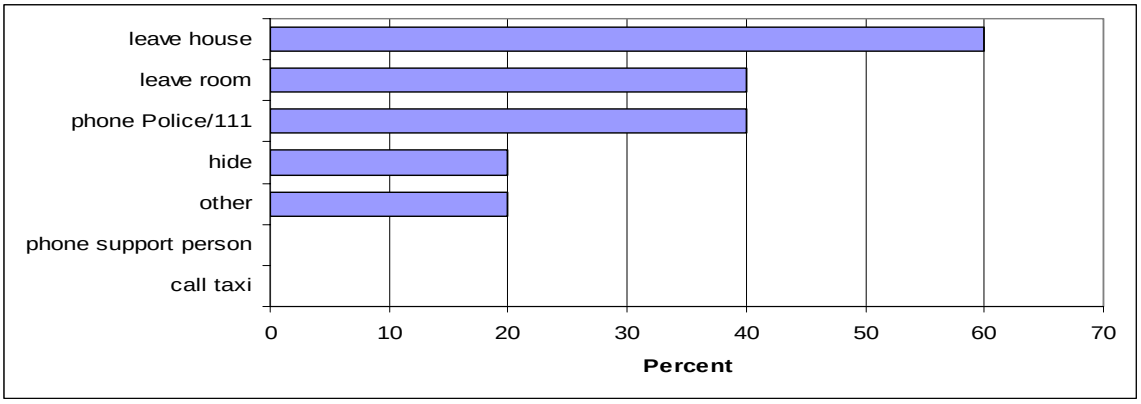
Advocates established a safety plan for children from 73 families/whanau (n=73; 82.0%). Figure 15 shows the components of the safety plan. In most families/whanau (n=50; 56.2%), children would leave the room in which the violence was occurring. In addition, 46 children (51.7%) would phone the Police or dial 111; and 44 (49.4%) would leave the house. Many children would adopt more than one strategy, for example, 'leave the room and 'call the police'.

Figure 15: Components of safety plan



When asked if there had been an occasion when children in the family/whanau had implemented and used the safety plan since its construction, five (5.6%) families/whanau reported having implemented and used the safety plan. Of these, the following strategies were used by the children: leave house (n=3; 60%); leave room (n=2; 40%); phone Police/111 (n=2; 40%); hid (n=1; 20%); and other (n=1; 20%), for example, went to grandparents (see Figure 16).

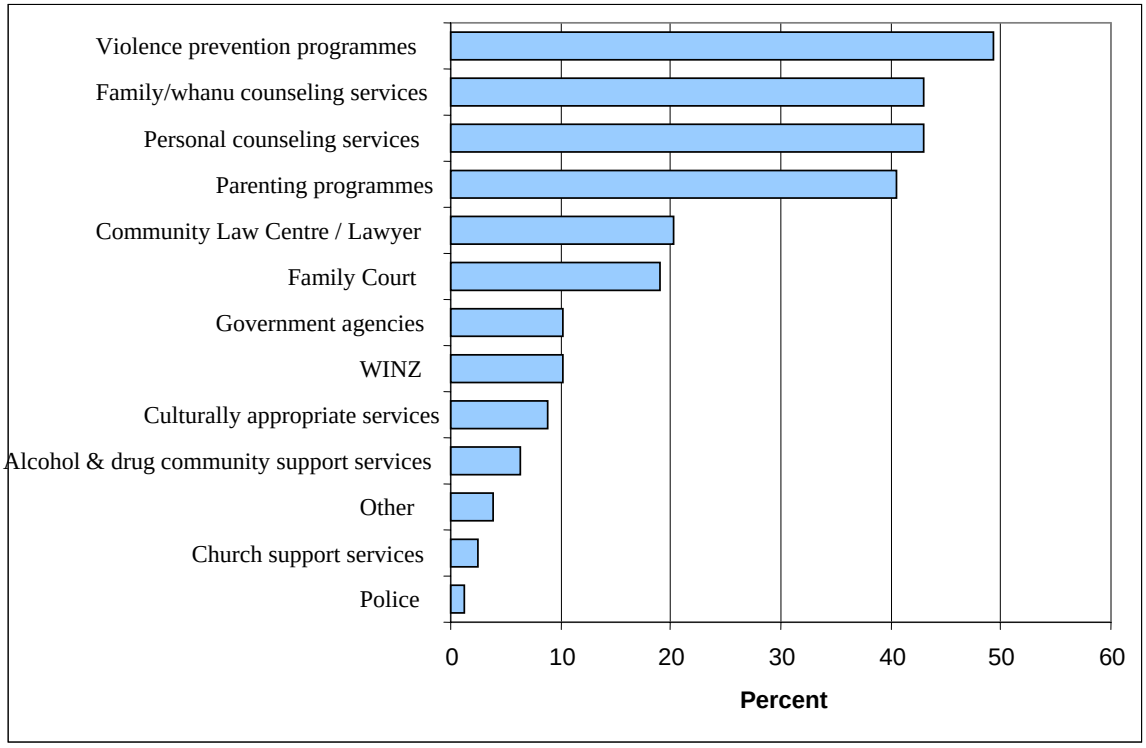
Figure 16: Components of safety plan used



Referral to other agencies

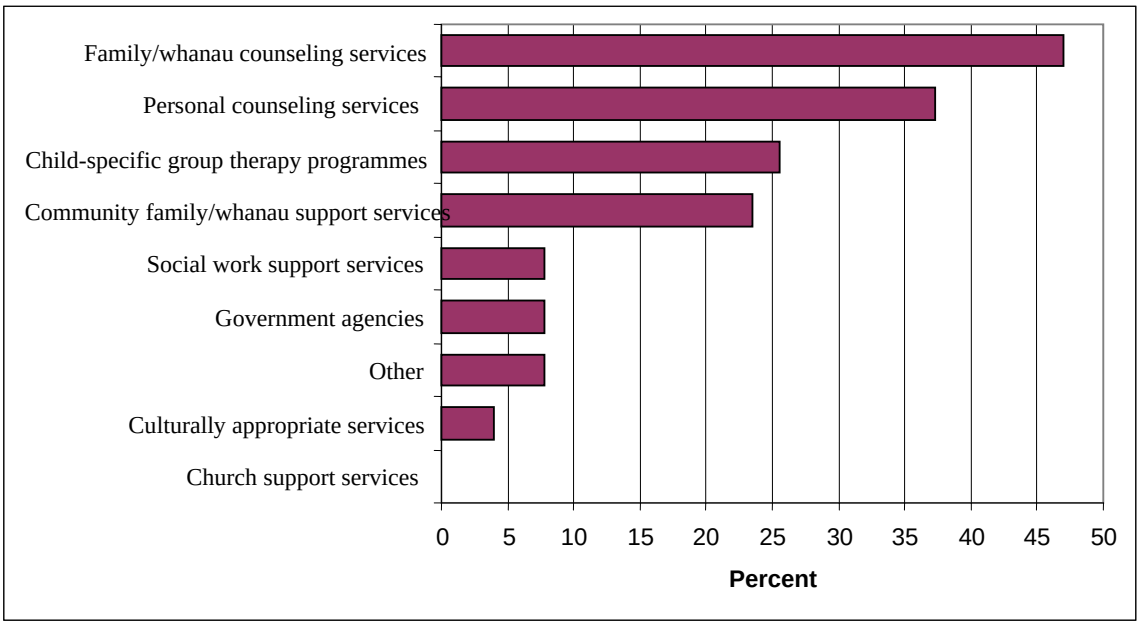
Most of the primary carers/mothers (n=79; 88.8%) had been referred to other agencies; eight (9.0%) had not. Most were referred to: violence prevention programmes (n=39; 49.4%); 34 (43.0%) were referred to family/whanau counselling services, and 34 (43.0%) were referred to personal counselling services, respectively; 32 (40.5%) were referred to parenting programmes; 16 (20.3%) were referred to a Community Law Centre/Lawyer; and 15 (19.0%) were referred to the Family Court. One (1.3%) was referred to the Police (see Figure 17).

Figure 17: Referral of mother to other agencies



Over half of the records (n=51; 57.3%) also showed that children had been referred to other agencies; more than one-third (n=32; 36.0%) had not. Most children (n=24; 47.1%) were referred to family/whanau counselling services; 19 (37.3%) were referred to personal counselling services. Just over one-quarter (n=13; 25.5%) were referred to child-specific group therapy programmes; 12 (23.5%) were referred to community family/whanau support services. Four (7.8%) were referred to social work support services; four (7.8%) were referred to government agencies such as Child Youth and Family Service; and four (7.8%) were referred to other agencies (see Figure 18).

Figure 18: Referral of children to other agencies



3.3. Implementation of the CCIP

Child advocates and the CCIP Co-ordinator were asked to reflect on the CCIP with particular consideration given to their perceptions of: the application of the CCIP model in practice; training, supervision and support processes; critical considerations related to ethnicity and gender; barriers to CCIP reach; and perceptions of the impact of the CCIP.

The CCIP model in practice

As previously stated, referrals to the CCIP occur via the POL 400 forms which are cross-checked against the DVC database.

> "I look on our database and check what history there is with that family with violence, like is there recent Police involvement and our involvement. I usually contact the caseworker who is that family's caseworker and have a chat with them about is this a suitable family for the child crisis team. If they say yes or I haven't dealt with them for six months because there's been no incidents or anything like that, then I will ring the family and normally ask to speak to the mum and say that I am ringing about the incident that occurred and just have a talk to her about the children and how are they and then I tell her a bit about what we know about children who witness violence and any sort of behaviors or emotional or cognitive developmental problems they might have and usually sometimes the mums say they do this or they do that they do wet the beds or they're in trouble at school" (Co-ordinator).

When discussing the CCIP with primary caregivers, it is stressed that the service is free of charge, and the service aims to assist the children. If primary caregivers want to access the service then, "I organise an advocate who will give you a call and arrange a time" (Co-ordinator). The woman's and child advocates are provided with family details by the CCIP Co-ordinator and are responsible for arranging initial appointments and subsequent visits with the families/whanau.

> "The advocates always get back to me in a couple of days and say we have made an appointment and this is the date and the time and that's all kept on file. From there they just feed back to me from their first visit if they have any concerns or worries or if they want to know whether CYF is involved because the abuse that is disclosed to them is quite severe or something like that. They just go through and complete their three visits and then send their

reports in. Quite often there is a bit of contact with the advocates because they usually have quite a few queries" (Co-ordinator).

Reflecting on CCIP practice the advocates considered that the primary purpose of the first visit was to establish rapport with children and the primary caregiver. With younger children, the rapport building process can incorporate drawing and playing games.

> "In the first session the women's advocate and myself will introduce ourselves to the Mum and differentiate our roles there with an emphasis on the Mum actually having somebody to speak to as a woman not just as a mother. I will use that as an opportunity to talk to the kids by themselves and introduce myself and usually just do some sort of rapport building to reduce the stress around what I am doing there. In the first session I usually get a good idea about what the children's perceptions of what's going on in the family, get their side of the story about basically what they want for their family, what they think they would like to see changed, what they want. A lot of it depends on the nature of the child as well. Much more detail the older the child, so the younger the child it tends to be more generic stuff around families" (Advocate).

> "If the children are younger you can't spend quite as much time with them actually talking, so for example I might talk to the children for 40 minutes and then they continue drawing the drawings or playing with the games that I bring while I hop off and speak to the mum for a couple of minutes and then I might come back and I try and keep it very relaxed depending on the situation" (Advocate).

Considering the goals of the three visits during the CCIP, advocates reflected that initially the primary focus was to "improve the immediate safety of the child on the day if possible." The aims of the second and third visits were to ensure that wherever possible by the third visit both the child and the mother "had tools and resources at hand that they didn't have before I went in that would allow them either to improve their own lives themselves or link into other services."

Training, supervision and support

An initial training session was provided to all child advocates at the beginning of the CCIP. The Co-ordinator and a senior advocate provided the initial training, and the team leader provides ongoing support to the advocates during delivery of the CCIP.

> "I had one or two hours training and an introduction with just the Co-ordinator and myself and then a group of all the new intake of child advocates and there were a few old advocates there as well. It was within two or three weeks of me starting" (Advocate).

One advocate interviewed started with the CCIP after the initial group training session and consequently did not receive any specific training. She considered that this was because she had experience and knowledge in the area.

> "I had three telephone conversations with the senior advocate about [the CCIP] and I had a meeting with the Co-ordinator which we did go through the paper work that she was giving me to read, the resources and I think it was pretty clear I could understand what she was talking about and had experience and knowledge in that area. They didn't give me specific training because I am a qualified counsellor in how to speak with children and all that. They just gave me all the information on what kind of things to look for, power and control issues from their philosophies basically."

Reflecting on supervision opportunities, the advocates commented that while there was no formalised supervision provided for the advocates by the DVC, there was however provision to discuss with the team leader any concerns the advocates may have had with a client.

> "At my instigation yes, not regular. Nothing formal from DVC. My supervision is to either email or call the Co-ordinator and say I would like to talk to you about a case. She is extremely accessible by phone and by email and there is ongoing consultation there."

> "Not as an advocate, although the Co-ordinator is always available. I had one case which shook me up quite a bit and I immediately rang the Co-ordinator and she just dropped everything and she just made herself totally available to debrief me over the phone. She asked me to come in which I didn't need to do because after talking to her I was OK again."

> "Not yet no. We were told we could do that on a once a month basis and there is a current case where I'm going to be ringing up to see if I can and talk to someone."

One of the advocates was located within a working situation with another advocate from the DVC so they provided regular peer supervision for each other: "we do lots of peer supervision because we work in the same office." Another advocate had external supervision relating to her own private practice, for which she met the costs:

"I do have my own supervision. No paid supervision through the DVC. I pay for my own supervision and I do use it for my domestic violence work."

In practice the CCIP advocates operate as a virtual team, with the Co-ordinator liaising with the advocates on an as-required basis. There appear to be no formal opportunities for the team of advocates to meet and reflect on their collective practice. Comments from advocates indicated that such opportunities would be beneficial to the continued implementation of the CCIP. As a means of encouraging collaboration, some advocates utilised existing peer support networks to support their CCIP activities.

> "I know some of them but we haven't met regularly. It would be really good to meet regularly and talk about any issues people have and even checking in that people are OK. I think that's a must" (Advocate).
>
> "There is no formal not outside of when we work together. It would be extremely useful because so many of these families have abuse ongoing and you're doing it but then you go home by yourself and you don't talk to anybody. It would be useful just to remind yourself that there's other child advocates too" (Advocate).

In an effort to encourage peer support, the DVC provide advocates with a newsletter:

> "The DVC put out a newsletter and the DVC provides us with information going out to everybody but there is no sort of coming together as such. I think it would be beneficial. I don't think it needs to be too often. I just think once in a while might be beneficial and also with the women's advocates as well because I think their knowledge is pretty good too, and that is an advantage" (Advocate).

The advocates were also asked to comment on training they had received from the DVC related specifically to the establishment of safety measures for themselves when delivering the CCIP. There was general consensus that the training addressed basic safety orientation, including ensuring that the perpetrator is not present at the time of the advocate visit. However, one advocate expressed a concern that the safety training was reliant on the existing skills of the advocates:

> "Again basic safety orientation. I think an assumption is that people know because I haven't worked with anybody that hasn't had quite an extensive experience where these things would already have been developed. We try to set things up for when the perpetrators are not there. If he is, it's just

> assumed that we know, well its not assumed because that's one of the big questions when we're hired and its one during the training workshop its covered, ways to keep yourself safe but its more sort of a reminder its not actually teaching, its just a quick going over."
>
> "[No specific safety training], not through the DVC no. Luckily for me I guess I come from a job in mental health so I had lots of training in crisis intervention and prevention and physical restraints in how to get out and all that sort of stuff for myself because I doubt if I would be as confident doing this without that training."

Two advocates also expressed some concern that the DVC did not supply advocates with cellphones:

> "We don't have cell phones supplied. I haven't taken a cell phone because I don't have one. It's one of the things I think is a must, is a cell phone. Even for myself I have started to take my partner's cell phone for my own protection"
>
> "There is the thing about ringing before you go and the fact that we usually go together and that's pretty much it. We are not provided with cell phones. I have a cell phone which I always make sure I carry with me."

Critical considerations relating to ethnicity and gender

The advocates work with families/whanau from a large variety of ethnicities, a high proportion of whom self-identify as Maori and Pacific Island with growing numbers from Asian and other immigrant and refugee groups. Wherever possible the CCIP Co-ordinator tries to "match culturally appropriate advocates with clients." The CCIP employ a Maori and a Pacific child advocate, and two Asian women's advocates. One advocate considered all families/whanau are unique, and therefore considered that she worked from a multicultural perspective. This same advocate also noted that she "battled her way through" when it came to language differences.

Another advocate acknowledged that it "had been a big learning curve" and while children had often adapted more to the dominant culture through their schooling experiences, for mothers/care givers this was less likely to be so. The advocate also noted that for a number of families/whanau, concerns were raised regarding confidentiality. This often involved Pacific peoples.

> "It's been a big professional issue for me because it is very, very different working with Pacific Island mums and to some degree children but the majority of the children I work with have been socialised and have had Pakeha teachers. The good part about being palangi is that their concern and it is an absolutely crippling concern about Pacific Island professionals and confidentiality, and that's been an immense barrier, and that's been something that I have had to adapt to on a family by family basis. You can see that confidentiality they have no trouble with that, but as soon as you start talking about referral stuff they don't want to go to Pacific Island groups and if the relationship is good enough they will come out and out say to you no because it will get back to somebody I know" (Advocate).

An advocate also commented that, often individual's understanding of English was more advanced than their spoken English and therefore it was important when interacting to not to speak down to people for whom English is a second language.

> "They've spent the majority of their professional interaction being spoken down to and having the perception that people think you're stupid."

It was also considered important by another of the advocates that "where you can do a cultural match that would be great and I think that would work better." Reflecting on interactions with Pacific families an advocate commented:

> "I have had one family where specifically the family has requested a Samoan speaking person and because the children were quite young I went into see the mother for most of the visits but as a child advocate. The younger children often just speak Samoan."

This advocate had had *"*no language difficulties to date.*"*

> "I've had families where I speak both Samoan and English or just Samoan if that's what the families want."

Another advocate indicated, that at times, access to an interpreter would have been helpful.

> "I would have loved to have brought in an interpreter. I have asked from the very beginning to have one and I don't mean professionally asked but vented that it is ridiculous that we don't have at least written material to leave behind in different languages. We do in Maori and Samoan and Tongan and things like that, but for the East African and South Asian groups no" (Advocate).

Comments from advocates suggested specific training relating to the area of cultural sensitivity appeared to be somewhat reliant on the existing skills of the advocates, and additional training provided by the DVC was a small part of the initial training session.

> "[I haven't received specific cultural training] not from the Domestic Violence Centre. I have had extensive stuff in the past, cultural sensitivity within that training workshop but not specific tools to take into. I would find that very useful."
>
> "I do have very specific training particularly for working with Maori cultures as part of my counselling training. So yes I probably have more knowledge of the Maori culture than any other culture but I still go in with the assumption that I know it."

A male advocate indicated there were a number of potential challenges in working in a sensitive area where the majority of clients were women who had experienced physical, emotional and/or sexual violence.

> "I am a man talking to a woman quite often about sexual violence, or physical violence in the home. You can almost see them sitting there thinking what are you, you're listening, and you're nodding and I know that you actually have a concern and you do want to achieve things for me but you have no idea what I am going through or who I am."

Reach of the programme and barriers to this

The Co-ordinator considered that the CCIP team could accept "way more referrals a week." Approximately 75% of families/whanau are already listed on the DVC database when a new POL400 is received by the DVC. The CCIP team is referred to the family/whanau because of the involvement of children, and an acknowledgement that the "nature of domestic violence is that it will happen again" (Co-ordinator). The CCIP team receives approximately '25-30 POL400's a week' (Co-ordinator), however the number of women taking up the service on behalf of their children is low: "we have found that only one in three families/whanau accept the service" (Co-ordinator). While the majority of families/whanau who refused the service do not provide a reason, those who did, did not consider that their children were affected by the violence. Additionally, many families/whanau were uncontactable by the DVC, for

example, many families/whanau had moved, did not have telephones or had unlisted numbers, and did not respond to letters informing them about the service.

Reflecting on potential opportunities to increase service utilisation, the CCIP Co-ordinator considered that if the CCIP was compulsory for all children in families/whanau where a POL400 was completed, then it would remove the option of refusal from the mothers. This would potentially minimize any recriminations a violent partner may take against a mother for bringing professional help to the family/whanau, and could also lead in the long term to a decrease in family/whanau violence.

> "I would like to see it mandatory. There are too many families who get the opportunity to say no to us. Some weeks the uptake is good. This week we only had three families uptake out of 20 I have rung and I can see by the POL 400's and I look on our database and I see all these incidents and they just say the kids are fine I don't want you. So I would like to see that when the Police are called to an incident they say that the child crisis team will be visiting. It wouldn't change the way we deal with them or our attitude but they wouldn't have a choice. We are speaking for the children and the children aren't getting any choice in the matter and I can understand the mothers would say no to us, I could definitely understand that they are trying to keep it all together and they would probably get in trouble. If the decision is taken off them if it is made mandatory, they can't be in trouble with their partners for it because it's not their choice. The partner would know that if he was violent then he would have to go into a programme as well as the children. If we did that, we would see a decrease in ten to twenty years time in the amount of domestic violence. Get mandatory" (Co-ordinator).

However, in contrast, an advocate considered it was important that autonomy and choice remained with mothers, and that the DVC could run the risk of becoming an agency with too much perceived power by the families/whanau.

> "I think the detriment of that would be that you would loose one of the most powerful things which is that the mum has made the first and hardest in my opinion step of saying that I would like someone to come in and help me and she has that power from the very beginning and everything can be built from that."

Advocates indicated that the availability and sustainability of referral agencies was often the biggest challenge to the reach of the CCIP. Part of the process of

delivering the CCIP intervention to families/whanau is referral (where necessary) of both children and mothers to community and government agencies for support. It was considered important for the ongoing success of the CCIP to have strong interagency collaboration. During the development and initial implementation stages of the CCIP, contacts were made with a number of agencies informing them of the service, and to ensure their availability as a referral agency for both mothers and children. However, professional expertise, particularly child counsellors and counselling services were almost non-existent in some areas, especially where demand was high.

> "Finding referrals finding ongoing support for the children. That's a huge challenge and I think that's going to be a bigger challenge."

Concerns were voiced by advocates about whether referrals appropriately matched the needs of mothers and children. Advocates desired further formal collaboration opportunities between the DVC and referral agencies to ensure that access and availability of services was congruent with the needs of the families/whanau.

> "We need to have greater collaboration with the referral agencies and when I say collaboration I don't mean talk and then not do jack, I mean actually change. If we need to change ours then we will change ours but I would like to be met half way by people for whom its in their best interests. If we refer on they get funding. They want client numbers. We're not trying to force something on them that they don't want to do but quite often we're working with families that for whatever reason are hard to get into counselling and hard to maintain within a therapeutic context but you can't use that as an excuse not to have them in. It's not just mum. Mum has reasons that she's not going there and the reason is almost never that she doesn't want to go in my professional opinion. There is a range of reasons and a lot of them are is that she's made bad choices, I'm not saying that she's blameless or that she has no responsibility for it but there are a lot of reasons and I don't think the referral agencies are picking it up. Not in my experience not in the Auckland area"

Where referral services were utilised, the advocates considered the children have responded well. Advocates considered a key factor in uptake of referral services was support for mothers to overcome perceived barriers to the uptake of referral services, either for themselves or their children, and also maintaining the referrals once the advocates have completed the three visits.

> "Mum hasn't used services, or more frequently has used services but they have fallen down in the past so what have been her barriers to doing that? So quite often it is things such as substance use, transport, her perceptions of what a counsellor would talk about, she's not ready to talk about her problems so or she doesn't want the kids to talk about theirs, she's still living with a violent partner who controls her so all of those things."

> "All of the therapeutic validity and fantastic training in the world isn't going to be worth squat if you are not working with the Mums and realise why she isn't going to turn up in the office with the kids and this is even for services that go into the home so this is not just mums not coming into the clinic it is that even services that do home visits which tend to be more social work orientated but they still go into the home are finding that its falling down and I just don't know how much I can do about that as a practitioner."

One advocate indicated that there was a need for more clarity around the whole referral process.

> "I think the challenges would be around where you're not clear where you have made a referral or whether you think a referral is needed to a certain agency."

Impact of the Intervention

Advocates considered the primary impact of the CCIP was evident in "all round benefits to the children." For example, when advocates from the child crisis team visit the families and talk to children, it is often the first occasion where the children's feelings in relation to witnessing family/whanau violence are acknowledged. This is also frequently the first time children are given a voice, and that action is focused on addressing the effects of family/whanau violence on the child. Advocates considered that safety plans are an effective empowerment tool for children.

> "Get away from focusing on adults talking at kids, and empower children to be able to think. The safety plan is really good at that because the safety plan says that if everything else goes to 'cack' then these are some ways that you and your brother and possibly your mum or your sister can be safe and you can do this, you don't need anybody else" (Advocate).

The process of reflection between the advocates and mothers about children witnessing and experiences as a direct result of the violence in their homes also often establishes a catalyst for change. Advocates reported that mothers often

reevaluate “their relationships with violent men and we are providing support and information to help them leave if they want to.”

> “At times I sit there with a crying woman after I’ve started explaining a little bit of what the children are going through. They just absolutely burst into tears because they have no idea. Often it’s a real catalyst for change” (Advocate).

Advocates commented that for a number of families/whanau, family/whanau violence is intergenerational. For some families/whanau having the child advocates working with the children has supported the breaking of this cycle. Overall, advocates considered that for mothers who availed themselves of referral services, and protection orders, the CCIP was a powerful and effective intervention.

> “I think we are breaking the cycle totally and utterly” (Advocate).
>
> “I think its an effective intervention. I think there’s some value in it and I think it works for some families. When I see families where the mothers then take control and follow up with what they are supposed to take up counselling for themselves, where they take up protection orders and then I think that’s effective.” (Advocate).

Advocates were asked to consider opportunities to enhance the probable impact of the CCIP. Two advocates indicated a challenge was measuring change in both physical and emotional behaviours in children within a three visit time frame. Two advocates noted that a return visit to families/whanau one month after the third visit would provide a more realistic measure of change for the children.

> “I would put it up to four sessions myself. I think three is very difficult. I would have three sessions and then I‘d have a break of like a month, have a fourth one as a built in follow up and I think in a month would then you would know whether it works. We certainly don’t want to be going in and working with these kids and quite often there is some retraumatising because they are talking about things that are disturbing and if it’s not helping then we shouldn’t be doing it. But if we had that fourth session we would be able to I’m not saying we would evaluate ourselves because I think there needs to be external validation of what we’re doing but we would be able to get a good measure of, well its been a month, how are things at school, at home, with your friends, how you’re sleeping, how you’re eating, how do you feel about your mum, your dad, yourself. I wouldn’t go much beyond that with kids” (Advocate).
>
> “I don’t think you necessarily can measure it in the first three” (Advocate).

The advocates indicated that these difficulties could be addressed with regular meetings “where we had everyone who is now working in the field bringing these issues there and starting to have some discussion and looking at what can be done.”

3.4 Impact of child crisis intervention

Mothers and children were asked to reflect on the emotional and physical behaviour of children, both at school and at home, since the last visit by the advocate. The majority of children and mothers noted positive changes for the children.

> "[The children] are no longer clingy and seem happy to do their own thing."
>
> "[We] they are bonding as a family and the children are happy and well adjusted"
>
> "[My daughter] is no longer consumed by sadness…she is able to concentrate better at school and generally much happier."
>
> "Has grown in confidence and is not clingy to mum anymore."
>
> "The boys lives are getting better and heading in a positive direction."
>
> "No feeling of fear or uncertainty about his place in the family… and reported that school was "awesome."

In three families/whanau where some improvements were noted, some of the children reported ongoing behavioral problems. In one family/whanau the violence was still continuing, however, in spite of this, the children had a better relationship between themselves, the "fear has been minimized", and they had been able to make some friends at school. In another family/whanau two children reported that they felt safer when they had access visits with the perpetrator of the violence. However, one child reported an ongoing anger problem and had started wetting the bed again since the renewed access visits. A mother with four children reported general improvement for three children, however, one child "remained argumentative with her and his brothers and initiated fights with them." However, the mother considered this was appropriate for his age and was not concerned.

Families/whanau were asked whether children could recall safety plans established in the initial visit with the advocates. Of the nine families, children from four could clearly recall the safety plan and had experienced an occasion to put the plan in action. The children had remembered to use the safety plan where appropriate and they considered it had worked. Children aged four and five from one family/whanau were putting the plan in action to the extent that whenever the parents raised their

voices slightly the children would go to their rooms and “remember very well to call 111 and state their details in fact they have been calling the police every time they get angry at each other or mum.”

Children from five families/whanau could not recall the safety plan, however, following prompting three could remember the plan. There had been no incidents where these families/whanau had needed to instigate the safety plan.

Families/whanau were asked whether they had utilised referral services. All families/whanau had been referred to services by advocates. Children from two families/whanau had not wanted to take up counselling services offered them. One child stated that she would go and see them when “she is ready.” Another child remains extremely reluctant to speak to others about his experiences. One family/whanau had been contacted by a counselling service and were due to attend early in 2004. One mother had inquired about the services she had been referred to but had not utilized a specific service. Overall she was very interested in receiving help, and considered she was not aware of all the options available.

Four families/whanau had experienced difficulties in accessing referral agencies. Two families/whanau had been unable to get appointments or get on the course they wanted. Another family/whanau reported that no referral agencies had recontacted them after the initial contact by the mother.

One family/whanau has been successful in obtaining approximately four sessions of counselling. The mother indicated that while she found this helpful “it didn’t cover much ground” and she also found it extremely difficult to have a conversation with the counsellor while the children were present as they kept distracting the process.

Families/whanau were asked to comment on the overall helpfulness of the advocates visits. Mothers and children from all families/whanau indicated positive outcomes from the advocate’s visits.

"Yes it was helpful. The explanations about children's behaviours, the safety plan and children's rights and that" (mother).

"Referring us to counselors and groups. I mean we didn't even know that stuff was out there"(mother).

"I had no idea about the effects on kids until you told me" (mother).

"Yes it was because we could open ourselves. We learned that we weren't all wrong, we were actually kind of right" (teenage male).

"All the different services that are out there, and just knowing that you're not alone" (mother).

"Another thing that is really good about the service is that when it is all happening, they come to you and it is free and available" (mother).

"Perfect" and I found it a lot helpful - can I have further visits with the advocate (teenage male).

"They gave me ideas about how to control my anger" (10 year old female).

All mothers commented that there were positive improvements with their children, both at school and at home, since the advocate visits.

"Really good, very busy, has doubled his maths."

"Has improved out of sight."

"Has been good for both kids."

"School work has been very good, good reports."

'Good."

"Fine."

Two mothers reported that since the visits had stopped, there had been better communication between them and their children.

" Has now opened up communication lines between us all."

"Going good between him and me"

The majority of mothers reported that an advocate for the children was both helpful for themselves, and the children. The visits by an advocate had provided the children with someone external to the family/whanau that they could communicate with and have their needs met. Some mothers had became more aware of what their children were going through, and in a number of instances better communication had been established between the family/whanau members.

> “I became more aware of what they were doing and not just looking at my stuff.”
>
> “She had been afraid to talk to me before about her problems but now opened up and there was better communication between us all.”
>
> “He is not being bullied anymore and there is better communication from the children.”
>
> “It was useful for him to be able to open up to someone outside the family and whanau.”
>
> “Made them a bit more secure a chance to open up to someone.”

Mothers were asked whether there had been an instance since the last advocates visit where the safety plan had to be put in place. However none of the mothers interviewed had had occasion for their children to instigate the safety plan. They also indicated that if they needed any further assistance they knew where to ask.

> “I don’t think so. The whole thing has bought us closer together.”
>
> “No, if needs be we have the advocates’ number.”
>
> “Don’t think so at the moment. I am always here for the children”

Mothers were asked whether they had been referred on to other agencies and if so, to reflect on their experience with these agencies. Three women had not received any referrals to outside agencies. Two of the women had been given pamphlets and referred to classes but had decided not to utilise any of these services. One woman had been referred to counselling but decided not to take it up. However, the children from this family/whanau had been referred to the ‘Families Forward programme” and she was intending to send them this year. Of the two families/whanau who had been referred to other services, one had a counsellor who came to the family/whanau on a weekly basis and one of the children was seeing a counsellor at school.

Mothers were asked to reflect on their experiences with the advocates. All of the mothers reported positive responses to the child advocacy service. Mothers found the child advocates supportive, helpful and were genuinely pleased that the children had had someone to talk to regarding the violence that had occurred in their homes.

“Great, I never thought the fighting or arguing affected them or that they saw what was happening. They wouldn’t have told me and would have always wondered whether they were to blame.”

“Wonderful, very insightful. We have reflected on what’s been happening and this has given me a different insight. Very worthwhile.”

“Very supportive. There if we are in need of help.”

“Yes a good service. It’s helped us.”

“Really good, really helpful. Giving me parenting advice and coping ways with the children.”

“Taught us how to look after ourselves when their father comes around.”

“Great help at the time they were needed. Very worthwhile.”

4.0 Concluding Comments:

The first aim of this evaluation was to assess opportunities for improving the reach and model of the CCIP. Evaluation findings indicate that while the programme receives approximately 30 referrals per week, the potential reach of the CCIP is somewhat compromised by some families/whanau who refuse to accept the offer of the service. There was some suggestion that the reach of the programme could be increased by incorporating mandatory participation, however, this option requires further investigation. Overall, evaluation evidence demonstrates that the CCIP model, incorporating visits to family/whanau by advocates, is acceptable to mothers and children. There was some suggestion that, in order to enhance the sustainability of positive change, the model could be adjusted to include a 'booster' visit, approximately six to eight weeks after the third visit. However the logistics of this (including implications for cost; potential family/whanau mobility) require further investigation. The additional 'booster' visit could also provide an opportunity to examine the potential impact of the CCIP.

The second and third aims of this evaluation were to examine the extent to which children exposed to family/whanau violence have poor health and wellbeing outcomes, and the effects of family/whanau violence on children's perceptions of their safety. Evidence from the case file review demonstrated that children in over half of the families/whanau reported having been exposed to psychological violence such as yelling or arguing between adults on a regular basis. In one-third of families/whanau, children reported having been exposed to physical violence, including witnessing hitting between adults, on a regular basis. Nearly three-quarters (73%) of families/whanau reported signs of physical and behavioural problems with children, including bed-wetting, difficulties at school, and self-harming behaviours. Prior to participation in the CCIP, nearly three-quarters of children reported responses at the time of family violence which potentially placed them at risk, including staying with their mother and asking adults to stop fighting. Evidence from the case file review indicates that safety plans were developed for the majority of children (82%). Safety plan strategies encouraged children to remove themselves

from the immediate risk of violence. Evaluation evidence indicated that children who had needed to utilise the safety plan were more able to recall the plans. An additional 'booster' session could be useful in reminding children of the plans.

The fourth and fifth aims of this evaluation were to examine changes in children's emotional responses to domestic violence, and changes in mother's beliefs about the impact of exposure to domestic violence on children's health and wellbeing. Evidence from the case file review demonstrated an overall positive change in the wellbeing of just under half of child participants (42%) during the three week implementation period of the CCIP (i.e., the three week period of the child advocate visits). All mothers interviewed commented on positive changes in children's physical health and emotional behaviour, both at home and at school, including reductions in children inappropriately assuming self-responsibility for violence in the home. Reflecting on the impact of the CCIP to change mother's beliefs about the impact of domestic violence on children's health and wellbeing, advocates indicated that participation in the CCIP was a powerful catalyst for change, enabling some mothers to reevaluate their relationships with violent partners. Evaluation evidence demonstrates that all mothers interviewed considered that the CCIP had increased their awareness of the impact of domestic violence on their children's health and wellbeing.

The sixth and final aims of this evaluation were to examine the level of uptake of support services by mothers of children who have received the CCIP service, and factors which may have influenced this. The majority of families/whanau who had received the CCIP services had also received referral to support services (89% of mothers; 58% of children). The majority of referrals were to violence prevention programmes, and family and individual counseling services. A number of barriers were identified to accessing and utilising referral services, including: cost; accessibility; service availability; child care; privacy and confidentiality concerns; and availability of culturally appropriate services.

In conclusion, evaluation evidence suggests the CCIP model is acceptable to families/whanau, and demonstrates a positive impact on improving the health and wellbeing of children who have been exposed to domestic violence. Family/whanau members consider CCIP advocates to be supportive, genuinely empathic, and providing a useful service to children.

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