Guidance for Recognizing and Responding Safely to Children's Exposure to Intimate Partner Violence

VEGA
FAMILY VIOLENCE
EDUCATION RESOURCES

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The guidance in this document summarizes the evidence about interventions for identifying and responding to children's exposure to intimate partner violence (IPV). Use of these strategies will be influenced by variations in provincial/territorial and local context, culture, and resources/service availability. For more information about the processes used to create this guidance, see here.

Healthcare and social service providers need to follow legislative requirements for mandatory reporting.

1. Ask questions about children's exposure to IPV when potential indicators are present.

Healthcare and social service providers should, without putting the child at increased risk, ask about children's exposure to IPV when potential indicators are present, including, 1) signs and symptoms in the child (e.g., physical injuries, if caught in violence between caregivers, or trauma symptoms), 2) behavioural and emotional indicators in the child (e.g., markedly oppositional behaviour) or caregiver (e.g., fearful, repeatedly cancelling visits) or 3) evidence-based risk factors in the caregiver (e.g., caregiver alcohol/drug misuse) or situation (e.g., financial strain). Universal screening for children's exposure to IPV is not recommended based on current evidence.

2. Offer immediate support to those who disclose children's exposure to IPV.

If healthcare and social service providers suspect or confirm that a child is being exposed to IPV or experiencing its consequences, assessment by a qualified professional is required. This can be within their typical work setting or another that is accessible. Immediate support characterized by the following should be offered: respectful, nonjudgmental interactions, active listening, compassion and good communications skills.

3. Women's shelters provide safety for children of women at immediate risk.

Women's shelters are residential facilities for abused women that may also provide services for children exposed to IPV. Shelters generally provide: 1) safe refuge in a time of crisis; 2) material support (e.g., food and clothing, as needed); 3) informational and system navigation support/advocacy; and 4) education and counselling. They may also provide transitional or "second-stage" housing. Many of these services may be available on an outreach basis for women and their children not residing in the shelter.

4. Offer referral to advocacy services to women who disclose IPV and their children.

Advocacy is an intervention that seeks to help current or past IPV victims and their children by providing them with IPV-specific advice (on safety planning and legal, housing or financial matters) and/or support to facilitate access to community resources (e.g., shelters, emergency housing, IPV outreach services, psychological interventions, social or other appropriate services). Advocacy should specifically take into account children who are exposed to IPV. Structured, brief advocacy interventions have been shown to be effective for women experiencing IPV, whether or not they are in a shelter at the time. The evidence for intensive advocacy interventions remains uncertain; therefore, no recommendation for or against is made here.

5. Consider psychological interventions for preschool-aged children (ages three to five) exposed to IPV who have specific symptoms, such as emotional or behavioural problems.

Psychological interventions involve professionals providing psychological help and advice to patients/clients, with the goal of relieving or healing psychological symptoms or problems. When used for children's exposure to IPV, sessions may be provided to the child only, or in child/parent dyads. Referral to these types of interventions is contingent upon assessment of the child for specific symptoms, such as emotional and behaviour problems.

6. Consider cognitive behavioural therapy (CBT) with a trauma focus for children (age five and older) who have been exposed to IPV and have post-traumatic stress disorder (PTSD) symptoms.

CBT with a trauma focus refers to different manualized CBT therapies that are focused on trauma. The essential principles of these therapies include the ability to reflect on, make connections among and change maladaptive trauma-related thoughts, feelings and behaviours. CBT with a trauma focus that has been designed for children exposed to IPV is recommended for children ages five and older who have been exposed to IPV and have PTSD symptoms; sessions should be at least eight weeks in duration and should include children and non-offending caregivers (with some joint sessions).

7. Consider child behaviour management strategies with advocacy for non-offending caregivers of children presenting with behaviour problems.

Child behaviour management strategies with advocacy is an intervention that involves manualized child management skills aimed at reducing children's behavioural problems. This intervention takes place over multiple sessions and involves role play and suggested homework assignments.

8. Consider referral to other evidence-based interventions.

Following a comprehensive assessment by a qualified provider, children may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). There is insufficient evidence to refer children to any other interventions simply on the basis of exposure to IPV; referrals to interventions should be based on an assessment of the needs of children and families. Interventions directed specifically to children exposed to IPV were found not to be supported by evidence at this time.

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How this guidance was created

VEGA developed this guidance by engaging expert children's exposure to IPV clinicians and researchers, who formed an evidence review group (ERG). The ERG set the scope of evidence to be collected, analyzed and evaluated in coordination with the mandate set by the Public Health Agency of Canada (PHAC): safe and effective strategies to identify, relate to and support those who have experienced family violence. Systematic reviews were conducted and analyzed by an independent team of experts, the McMaster Evidence Review and Synthesis Team (MERST), in consultation with an expert from the MacGRADE team. The GRADE (Grading of Recommendations, Assessment, Development and Evaluations) methodology was then applied to create the above guidance statements. These guidance statements were reviewed by VEGA's National Guidance Implementation Committee (NGIC), which is composed of representatives from 22 key Canadian health and social service professional organizations invited to participate in VEGA by the federal minister of health.

For further information

Please refer to VEGA's online education resources about children's exposure to IPV, including the Recognizing and Responding Safely to Child Maltreatment Module and the Handbook Sections on children's exposure to IPV and IPV. (https://vegaeducation.mcmaster.ca/).

Sources

1. World Health Organization. Update of the mental health gap action programme (mhGAP) guideline for mental, neurological and substance use disorders [Internet]. Geneva, Switzerland; 2015. Available from: https://www.who.int/mental_health/mhgap/guideline_2015/en/

2. World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines [Internet]. Geneva, Switzerland; 2013 [cited 2015 May 17]. Available from: http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/