Children's Exposure to Intimate Partner Violence Systematic Review Summary

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[i] The views expressed herein do not necessarily represent the views of our funder, the Public Health Agency of Canada.

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Introduction

Children's exposure to intimate partner violence[ii] is a widespread problem with significant impacts on the health and well-being of children in both the short and the longer term. [1–7] Emerging evidence indicates that certain interventions (see below) may be beneficial and that clinical awareness of this exposure may lead to more accurate assessments of and responses to presenting indicators, including emotional difficulties (e.g., internalizing symptoms, such as anxiety) and behavioural problems (e.g., externalizing symptoms, such as hostility, irritability, uncooperativeness).

Our review group systematically evaluated and synthesized the available evidence, including following a modified GRADE [8] process with VEGA Evidence Review Group topic experts, to arrive at guidance statements for identification and intervention/referral. The children's exposure to intimate partner violence Evidence Review Group also attempted to contextualize the guidance for Canada, having discussions that will continue with the National Guidance and Implementation Committee (NGIC).

Note that most research has been conducted on interventions for women exposed to intimate partner violence by male partners and children exposed to intimate partner violence in the context of these heterosexual relationships/family contexts. There is relatively little evidence (and none that met this review's design criteria) on interventions for children exposed to violence in same-sex couples, for men who are victims of women perpetrators or for gender-diverse parents.

In some cases, where evidence was lacking, we used the mechanism of *good practice statements*. [9] These are intended to guide healthcare and social service providers in recognizing and responding to children exposed to intimate partner violence based on the best available evidence and expert clinical judgment. Given the interrelated nature of intimate partner violence and children's exposure to intimate partner violence, it is important to remember that the child and their non-offending parent both require care and support. Therefore, in some cases, we explicitly link care of the mother and child in our guidance statements. Related to this, some interventions are designed for both women and children experiencing intimate partner violence—studies reporting on child outcomes are included in this set of guidance statements, while those reporting women's outcomes are reported in the intimate partner violence guidance statements. When this happens (i.e., for the Advocacy and the Shelters interventions), the guidance statements are explicitly linked.

[ii] According to the World Health Organization, intimate partner violence includes multiple forms of physical, emotional/psychological and sexual abuse, including controlling behaviours such as financial abuse. For the purposes of this guidance, we define exposure to intimate partner violence as a child being aware of (including, but not necessarily directly witnessing) violence between his or her caregivers. Children may also be "exposed" without knowing about the violence if they are impacted by the consequences of the intimate partner violence on their caregivers, such as mental health problems or disrupted parenting. Excluded are exposure to other forms of conflict in the home, including conflict between caregivers, or violence or conflict between other family members.

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Summary of Guidance for Children Exposed to Intimate Partner Violence Identification and Response

Intervention	Recommendation	Comments
Recommended		
Identification	Identification through case-finding (defined below) is recommended. Initial response to a positive identification should involve providing safe and supportive responses.	Good practice statements.
Shelters and Transition Houses	Women's shelters provide safety for women at immediate risk, and their children.	Ideally, a process of safety planning with the caregiver experiencing intimate partner violence will be undertaken to determine whether a shelter or other safe accommodation is best.
Advocacy	Advocacy interventions for adults exposed to intimate partner violence that specifically take into account their children, should be considered for children exposed to intimate partner violence.	See Intimate Partner Violence Systematic Review Summary for related recommendations on advocacy.
Psychological/Counselling/ Psychotherapy FOR PRESCHOOL AGE CHILDREN (ages 3–5 years) NOTE: Although cognitive behavioural therapy (CBT) is a type of psychotherapy, in these reviews it is considered separately.	Psychological interventions that include components for mothers and children, as well as joint sessions, and follow specific protocols, should be considered for preschool children (ages 3–5 years). Referral to these types of interventions depends on assessment of the child presenting with emotional and behavioural problems.	
Cognitive Behavioural Therapy FOR OLDER CHILDREN (> age 5)	Cognitive behavioural therapy with a trauma focus (specifically designed for the context of intimate partner violence), with separate therapy sessions for children and mothers (and some joint sessions) should be considered for children over the age of 5 years with post-traumatic stress symptoms.	There is no evidence of CBT's effectiveness for children 5 and younger exposed to intimate partner violence.
Child Behaviour Management Skills Training with Advocacy	Training on child behaviour management strategies, combined with advocacy, should be considered for mothers when children present with behaviour problems.	

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Other evidence-based interventions	Following an assessment by a qualified provider, children exposed to intimate partner violence may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer children exposed to intimate partner violence to any other interventions simply on the basis of this exposure. Referrals to interventions should be based on an assessment of the needs of the individual.	Treatment should be in accordance with WHO mhGAP intervention guidelines (10) and/or national or profession-specific practice guidelines, delivered by professionals with a good understanding of children's exposure to intimate partner violence and its consequences.
Cannot Recommend For or Against		
Psychoeducational Interventions NOTE: these interventions vary but generally include things like teaching children coping skills, how to express emotions, and content on knowledge, attitudes and beliefs about violence. This does not include education as part of other interventions outlined above and below.	There is insufficient evidence to recommend either for or against psychoeducation for children exposed to intimate partner violence.	
Child Behaviour Management Skills Training without Advocacy	There is insufficient evidence to recommend either for or against interventions that include child management skills, in general, for children exposed to intimate partner violence.	
Not Recommended		
Psychological/Counselling/ Psychotherapy Interventions FOR OLDER CHILDREN (> age 5) NOTE: Although cognitive behavioural therapy (CBT) is a type of psychotherapy, in these reviews it is considered separately	Psychological interventions are not recommended for children exposed to intimate partner violence..	
Play Therapy	Play therapy is not recommended for children exposed to intimate partner violence.	

1. Recognition of Children's Exposure to Intimate Partner Violence

The potential benefits of identifying children exposed to intimate partner violence are complex and may only be realized when identified by a trained healthcare or social service provider in a safe manner. Providers are encouraged to review VEGA's Family Violence Education Resources for guidance on how to recognize and provide a safe initial response to children with this exposure. Remember that one of the most direct ways to prevent children's exposure to intimate partner violence is to ensure the safety of the caregiver (usually the mother) who is experiencing violence.

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The following good practice statement should guide healthcare and social service providers in identifying children exposed to intimate partner violence. This statement updates the World Health Organization's recommendation about identifying children exposed to maltreatment, as published in the Mental Health Gap Action Programme (mhGAP) update. [11]

a) Identification

The two main approaches to identifying children exposed to maltreatment, screening and case-finding, are often contrasted with each other. Screening involves applying a standard set of criteria to evaluate children's potential exposure to intimate partner violence in all presenting children (or a subset of children). Case-finding, alternatively, requires that clinicians are alert to the signs and symptoms of child maltreatment. Instead of using standardized tools or questions, case-finding entails clinicians asking the child about their potential exposure in a way that is tailored to their presentation

Recommendation

Identification through case-finding is recommended. Healthcare and social service providers should, without putting the child at increased risk, ask about children's exposure to intimate partner violence when potential indicators are present, including:

1) signs and symptoms directly related to abuse exposure (injuries, mental health issues such as depressive or post-traumatic stress symptoms);
2) behavioural indicators or cues on the part of abused parent (e.g., cancelling visits, increasing use of health services, deferring to partner in visit) and/or the abusive parent (always present, answering for partner, etc.); and
3) specific evidence-based risk indicators (e.g., alcohol/drug misuse, financial strain, recent separation).

If children's exposure to intimate partner violence is suspected or confirmed, a qualified professional's assessment is required, followed by a referral to evidence-based interventions and subsequent follow up. Universal screening of children's exposure to intimate partner violence is not recommended based on available evidence.

See the Child Maltreatment Systematic Review Summary and Intimate Partner Violence Systematic Review Summary documents for similar recommendations for these exposures.

Summary of the evidence

Existing research is generally weak regarding how to identify children's exposure to intimate partner violence, as well as on the link between identification and child outcomes. A major gap is the lack of longitudinal studies following children from identification to any form of immediate or later intervention. Although a number of tools exist to measure children's exposure to intimate partner violence, their utility in clinical contexts is largely unknown and there is no single tool that is appropriate across all settings, presenting symptoms or age groups. When children's exposure to intimate partner violence is suspected, there is some evidence to suggest that reports from multiple informants (e.g., child and parent) regarding exposure should be obtained when possible. However, there is no available evidence regarding the effectiveness of initial responses to a child

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who is identified, either through inquiry or self- or parental disclosure.

Care must be taken in identifying a child exposed to intimate partner violence because of the potential harms to the child, which can include misidentification and labelling as well as a children being revictimized after a report. Revictimization may occur if a child experiences worsening abuse from the original caregivers or while in foster care environments that children experience as more detrimental than their family of origin. Possible harms to the non-offending parent include the potential escalation of violence once reports are initiated and the abusive partner becomes aware of the proceedings or loss of their child(ren) to child protective services. It is important not to communicate a punitive message regarding parenting to mothers who have accessed intimate partner violence services.

2. Referral Pathways for Children's Exposure to Intimate Partner Violence

Below we review interventions specific to children's exposure to intimate partner violence. Providers should also consider other evidence-based interventions if the assessment of the child identifies other mental health symptoms or disorders (e.g., depression).

a) Shelters and Transition Houses

Recommendation

Women's shelters provide safety for women at immediate risk, and their children. (Intervention is strongly recommended, based on immediate safety concerns; the body of evidence was rated as very low certainty.)

Remarks[iii]

Shelters include all residential facilities, such as transitional or emergency housing, for individuals exposed to intimate partner violence (and their children, including infants). Such shelters generally provide women and their children with four distinct types of services/support: 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. In reducing re-exposure to intimate partner violence and harm by removing the child from the abusive environment, shelters offer immediate safety. Providers who recommend shelters must balance prioritizing safety with the children's and women's needs, such as access to schools. Acceptability to children varies—with, for example, older children reporting less satisfaction with shelter rules. Despite moderate system costs, the absence of user fees increases access for vulnerable groups, working toward greater equity. Challenges may need to be overcome, however, in areas with less access (rural/remote and for people whose needs might not be met by virtue of culture, religion, disability status, etc.).

Summary of the evidence

The evidence for shelters and transition houses for children exposed to intimate partner violence was rated as very low certainty, primarily due to the lack of comparative designs that assess children's outcomes. Large-scale studies that examine multiple outcomes and overall

iii "Remarks" summarize key points related to scope, acceptability, equity and other considerations discussed by the Evidence Review

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effectiveness are uncommon. One example is a non-comparative descriptive evaluation of overall shelter services in the U.S. that assessed immediate outcomes associated with shelter stay from approximately 3400 women in 215 domestic violence shelters from 8 states. [12]

Shelters are never accessed by the child alone, but with their mother. Additional information about shelter recommendations can be found in the Intimate Partner Violence Systematic Review Summary.

b) Advocacy Interventions Delivered to the Non-Offending Caregiver/ Mother

Recommendation

Advocacy interventions for adults exposed to intimate partner violence that specifically take into account their children, should be considered for children exposed to intimate partner violence. (Conditional recommendation for intervention based on the benefit of advocacy for women experiencing intimate partner violence; the body of evidence was rated as low certainty.)

Remarks

Advocacy interventions provide caregivers (and their children) with intimate partner violence-specific advice (on safety planning and legal, housing or financial matters) and/or support/ empowerment to access to community resources (e.g., refuges/shelters, emergency housing, psychological interventions). Advocacy may be offered in community, healthcare or shelter settings and is implemented by trained advocates with ranging professional status. Advocacy interventions can vary in intensity/duration, including one brief session or multiple longer sessions. The availability and use of advocacy interventions in Canada are not known. However, the 2009 General Social Survey [13] reports that women exposed to intimate partner violence access intimate partner violence-related services at community/family centres (13%), women's centres (5%) and shelters/transition homes (4%), all of which may offer advocacy for children as well as women. One snapshot of Canadian shelters (a common setting for advocacy) indicated that among women seeking shelter for intimate partner violence on a single day, 51% were admitted with their children.[14] It should be noted that the present review and guidance statement do not refer to the child advocate process as detailed within respective provincial legislation.

Advocacy services vary by geography (rural/remote versus urban) and by who uses them. For example, while shelters (a common setting for advocacy, as noted above) are widely accessible, they are not being used, for a variety of reasons, by the majority of abused women and their children. Shelters are disproportionately accessed by low-income women. Thus, further work and consideration is needed around the utility and effectiveness of advocacy interventions for children exposed to intimate partner violence for those who come from more middle-/high-income homes, who are non-English/French speaking and who belong to cultural and sexual minority groups. Shelters may also be limited with respect to their support and advocacy of older male youth and of women with mental health or substance use issues.

Advocacy interventions are likely acceptable to clients (parents and children) and providers (those referring to and those providing service) as they generally involve understanding client needs and developing coordinated care and referral plans and pathways. The costs and cost-benefit considerations are unknown. Equity was deemed to probably be increased, especially by forms of

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advocacy delivered at no cost to women and children through shelters or other community-based services.

Summary of the evidence

There is low certainty in the existing research. One randomized controlled trial (RCT) with 206 children examined the effects of a specific type of advocacy intervention on the children's emotional and behavioural problems.[15] Results did not reach a threshold that was clinically meaningful, indicating there may be little to no difference in children's symptoms between those who received the advocacy intervention and those receiving usual care.

Advocacy, as defined in this document, is rarely if ever provided to the child alone—most often, it is provided to the woman exposed to intimate partner violence. Additional information about a recommendation for advocacy can be found in the Intimate Partner Violence Systematic Review Summary.

c) Psychological/Counselling Interventions

Recommendation

FOR PRESCHOOL AGE CHILDREN (ages three to five years), psychological interventions that include components for mothers and children, as well as joint sessions, should be considered. Referral to these interventions depends on whether the child is assessed as having emotional and behavioural difficulties. (Conditional recommendation against intervention; the body of evidence is rated as very low certainty or there is no evidence).

FOR OLDER CHILDREN (> age five), on the basis of exposure to children's exposure to intimate partner violence alone psychological interventions other than CBT (see below) are not recommended. Note that this is a conditional recommendation against this intervention on the basis of *exposure to intimate partner violence alone*; however, the effectiveness of this intervention for specific symptoms (e.g., anxiety) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for specific symptoms and problems experienced by children. (Conditional recommendation against intervention; the body of evidence is rated as very low certainty or there is no evidence).

Remarks

Psychological/counselling interventions (also referred to as psychotherapy) for children's exposure to intimate partner violence can take various forms and vary in intensity/duration: interventions may occur in an individual or a group setting; they may be provided by clinical psychologists, social workers or others trained in counselling; they may be provided in various settings (e.g., community vs. institution); they may vary on whether intervention is provided to the child only or in child/caregiver dyads. Although CBT is a type of psychotherapy, in this review, it is considered separately. The costs of the intervention likely vary (moderate to high) depending on who is providing the service and where, and the certainty of the evidence around costs is low, but consideration of costs versus benefits probably favours the provision of psychological interventions. Equity is probably reduced since this type of intervention is not widely available and patients would likely accrue costs (e.g., transportation to specialized facilities, costs of therapists

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not covered by provincial or other insurance). Acceptability to clients (caregivers and children) and providers was deemed unknown. Key factors for clients include costs, accessibility and a long treatment period (50 weeks). For providers, key factors include the need for a manual approach, training and a long treatment period.

See the Child Maltreatment Systematic Review Summary for counselling/therapy recommendations specific to this exposure.

Summary of the evidence

There is low certainty in the evidence. One RCT examined psychological interventions in preschool-aged children (mean age: four years).[16] This RCT involved separate group-based components for mothers and children, as well as a joint family therapy group, and reported on post-traumatic stress disorder (PTSD) symptoms and overall emotional (internalizing)/behavioural (externalizing) symptoms.[16] There may be a greater reduction in PTSD symptoms and emotional/behavioural symptoms with psychological counselling compared to usual care (in this trial, usual care included assessment feedback, case management and community referral). The study did not report on harms.

There is no evidence available for school-aged children and the intervention tested was quite specific, including the child and parent(s). The effects of other psychological interventions for children's exposure to intimate partner violence are unknown.

d) Cognitive Behavioural Therapy (CBT)

Recommendation

FOR OLDER CHILDREN (> age five), cognitive behavioural therapy with a trauma focus (specifically designed for the context of intimate partner violence), with separate therapy sessions for children and mothers (and some joint sessions), should be considered for children over the age of five years with post-traumatic stress symptoms. (Conditional recommendation for intervention; the body of evidence was rated as low to very low certainty.)

Remarks

CBT, generally speaking, attempts to challenge distorted, negative thought patterns in order to help people develop more adaptive cognitions and behaviours. The extent to which CBT is used in Canada is unknown, though, as universal healthcare funds the psychotherapy administered by physicians or, in the case of non-physician therapists, those employed by public institutions. CBT administered by psychologists or other non-physicians may be covered by insurance, but more often than not it is covered out of pocket by clients themselves. CBT was thus deemed to have moderate costs, but the certainty of the evidence around costs is uncertain. Equity is probably reduced due to the likely costs accrued by patients (e.g., transportation, time off work), although overall cost effectiveness seems to favour providing CBT. Acceptability to clients and providers was deemed acceptable, though the study reviewed below reported a relatively high dropout rate (~40%).

See the Child Maltreatment Systematic Review Summary for counselling/therapy recommendations specific to this exposure.

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Summary of the evidence

There is low to very low certainty of evidence for using CBT with children exposed to intimate partner violence. One RCT, involving children over age five, examined the use of trauma-focused CBT (TF-CBT) during 45-minute individual therapy sessions (for children and mothers) for eight consecutive weeks.[17] There may be a reduction in anxiety and PTSD symptoms with TF-CBT compared to usual care, and a reduction in depression, but the evidence supporting this reduction is uncertain. There may be little to no difference in externalizing symptoms with CBT compared to usual care. The intervention seems to reduce serious adverse events, such as child self-injury. Studies meeting inclusion criteria have not been done to measure the effectiveness of CBT among preschool children exposed to intimate partner violence.

e) Psychoeducational Interventions

Recommendation

There is insufficient evidence to recommend either for or against psychoeducation, as a single mode of intervention, for children exposed to intimate partner violence. This should be differentiated, though, from providing basic knowledge about intimate partner violence and its potential impact on the short- and long-term health and mental health outcomes of children and adolescents, available resources, etc. However, if education is offered (alone or as part of other interventions), it should be well-articulated in terms of components, modes of delivery and links to specific child outcomes. (No recommendation for or against; the body of evidence is rated as low certainty.)

Psychoeducational interventions for children's exposure to intimate partner violence can take various forms. They may vary in intensity/duration; whether they occur in an individual or, more often, a group setting; who provides the service and where; and whether they incorporate the non-abused caregiver alongside the child. Studies included in this review involved, for example, teaching children coping skills, how to express emotions, as well as content on knowledge, attitudes and beliefs about violence. For mothers, interventions included information on parenting/child management skills and social/emotional adjustment. Although we did not find studies that evaluated costs, fees likely vary, and the direct costs to clients/parents would reduce accessibility and equity. Although this type of intervention is likely acceptable to clients and providers, there are no relevant studies.

Summary of the evidence

There is low certainty of evidence for psychoeducation interventions (including basic parenting information, but not parenting skills training) for children exposed to intimate partner violence. One controlled clinical trial[18] and two RCTs[19,20] examined psychoeducational interventions and included parents (mostly mothers) and children, mainly in group formats. All three studies examined overall emotional and behavioural problems. There may be little to no difference in symptoms after psychoeducational interventions compared to usual care (the difference did not reach a threshold that was clinically significant). One RCT found that children's PTSD symptoms (parent and child reports) may be greater and there may be more children with a clinical level of PTSD symptoms with psychoeducational interventions than usual care.[20] The same trial found there may be a greater increase in depressive symptoms with the psychoeducational interventions.[20] None of the three studies included in this review reported on adverse events/harms.

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f) Child Behaviour Management Skills Training, With and Without Advocacy

Recommendation

Interventions that combine training on child behaviour management strategies with advocacy are recommended for the non-offending parent/caregiver of children exposed to intimate partner violence who present with externalizing problems. (Conditional recommendation for intervention; the body of evidence was rated as very low certainty.)

NOTE: This conditional recommendation is based on evidence of benefit for advocacy (see above) and existing systematic reviews suggesting child management interventions are generally effective at reducing conduct problems in children. There is insufficient evidence to recommend for or against child management interventions without an advocacy component. (No recommendation for or against; the body of evidence is rated as very low certainty.)

Remarks

Multi-component interventions combine two or more distinct forms of intervention, usually including advocacy and child behaviour management strategies. For the one intervention reviewed, parenting skills were explicitly excluded. These interventions may vary greatly in intensity/duration; whether they occur in an individual or a group setting (or both); who provides the service (e.g., clinical psychologists, social workers or a variation); where the intervention is situated (e.g., community vs. healthcare setting); and whether the child and/or the abused caregiver is involved in the various components. Multi-component interventions may not be labelled as such and therefore can be difficult to identify without knowing the details of the intervention.

Although we did not find relevant studies assessing costs, these are likely moderate. The level of equity is likely to vary depending on where and how services are accessed and the associated costs to the client. Acceptability to clients and providers was deemed unknown as there are no relevant studies.

Summary of the evidence

There was very low certainty of evidence for the type of multi-component intervention available for this review—child management skills training with advocacy—for children exposed to intimate partner violence. Two RCTs examined the same intervention.[21,22] Both studies involved mothers and their children (36 and 66 dyads) and provided mothers and children with social support and problem-solving skills (advocacy) and mothers with child management skills. Both reported on behavioural symptoms and one on emotional symptoms. Post-intervention, there may be a greater reduction in emotional and behavioural symptoms with this intervention, but this is uncertain as there were very few children in the studies and the studies were at high risk of bias. Adverse events were not reported in either study. Available follow-up data is limited and generally at very high risk of bias.

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g) Other Evidence-Based Interventions

Recommendation

Following assessment by a qualified provider, children exposed to intimate partner violence may need to be referred to evidence-based treatments for specific symptoms or conditions (e.g., depression) or other concerns (e.g., substance use). At this time, there is insufficient evidence to refer children exposed to intimate partner violence to any other interventions simply based on this exposure; referrals to interventions should be based on an individual needs assessment. Mental health care, in accordance with WHO mhGAP[12] intervention guidelines and/or national or profession-specific evidence-based practice guidelines, should be delivered by professionals with a good understanding of children's exposure to intimate partner violence and its consequences.

h. Play Therapy

Recommendation

On the basis of exposure to children's exposure to intimate partner violence alone, play therapy is not recommended for children exposed to intimate partner violence. Note that this is a conditional recommendation against this intervention on the basis of *exposure to intimate partner violence alone*; however, the effectiveness of this intervention for specific symptoms (e.g., anxiety) or problems (e.g., substance use and addiction) is outside of the scope of this review. Providers should also consult relevant practice guidelines about other evidence-based interventions for specific symptoms and problems experienced by children. (Conditional recommendation against intervention; the body of evidence was rated as very low certainty.)

Remarks

Though it is often referred to in more general terms, play therapy is in fact a specific type of psychological intervention. In this review, it has been examined separately from CBT and other psychological/counselling interventions. Play therapy is used for children with behavioural or emotional problems, such as those who have experienced trauma, and can take several forms, such as "child-centred play therapy," "non-directive play therapy," and "family play therapy." Sessions are usually facilitated by a play therapist who is often a MA- or PhD-prepared counsellor with specific training. During therapy, children learn coping skills, express feelings and increase their understanding of life experiences through play (e.g., using puppets, toys, drawings, and word games). Play therapy was deemed of moderate cost, based on low certainty of evidence. It is likely to reduce equity due to direct costs and limited accessibility (fewer than 20 registered play therapists are listed in a Canadian registry, although the extent to which other mental health professionals with some training but no certification may practice play therapy is unknown). Acceptability to clients and providers was deemed unknown. Overall, there are uncertain benefits, moderate costs and limited accessibility.

Summary of the evidence

The evidence for play therapy for children exposed to intimate partner violence is of very low certainty. Two controlled clinical trials examined play therapy.[23,24] One involved eight 30-minute sessions of structured mother-child play in 37 dyads. The other studied 12 45-minute individual children-centred play therapy sessions with 22 children. Each included one relevant outcome: the

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first measured overall emotional/behavioural symptoms and found that there may be a greater reduction in symptoms after play therapy compared to usual care. The second measured parent-child relationships (specifically, the quality of parent-child interaction) and found that there may be a greater improvement in interactions after play therapy compared to usual care. Other essential and important outcomes, including adverse events, were not measured in the studies.

For further information

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

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