CHILDREN'S MENTAL HEALTH RESEARCH

Quarterly

FALL 2012 VOL. 6, NO. 4

Intervening after intimate partner violence

Fall

Quarterly

VOL. 6, NO. 4, 2012

Children's Health Policy Centre

ABOUT THE CHILDREN'S HEALTH POLICY CENTRE

As an interdisciplinary research group in the Faculty of Health Sciences at Simon Fraser University, we aim to connect research and policy to improve children's social and emotional well-being, or children's mental health. We advocate the following public health strategy for children's mental health: addressing the determinants of health; preventing disorders in children at risk; promoting effective treatments for children with disorders; and monitoring outcomes for all children. To learn more about our work, please see www.childhealthpolicy.sfu.ca.

ABOUT THE QUARTERLY

In the *Quarterly*, we present summaries of the best available research evidence on children's mental health topics, using systematic review methods adapted from the Cochrane Collaboration (www.cochrane-handbook.org). The publication is funded by the British Columbia Ministry of Children and Family Development.

QUARTERLY TEAM

Scientific Writer
Christine Schwartz, PhD, RPsych

Scientific Editor
Charlotte Waddell, MSc, MD, CCFP, FRCPC

Research Coordinator
Jen Barican, BA

Research Assistant
Larry Nightingale, LibTech

Production Editor
Daphne Gray-Grant, BA (Hon)

Copy Editor
Naomi Pauls, BA, MPub

SFU
SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

This Issue

NEXT ISSUE

Preventing adolescent dating violence

Intimate partner violence is not limited to adults. Many adolescents also experience aggression from dating partners. In the next issue of the *Quarterly*, we explore how to prevent this form of violence.

Teen's suicide highlights concerns about bullying

The recent death by suicide of a Port Coquitlam teen is being investigated by RCMP to determine if online bullying, blackmail and physical assaults at school were contributing factors in her death. The Children's Health Policy Centre strongly supports using effective interventions to eliminate the needless suffering associated with bullying and suicide. To this end, we draw readers' attention to our previous issues on antibullying interventions and antisuicide interventions.

How to Cite the *Quarterly*

We encourage you to share the *Quarterly* with others and we welcome its use as a reference (for example, in preparing educational materials for parents or community groups). Please cite this issue as follows:

> Schwartz, C., Waddell, C., Barican, J., Garland, O., Gray-Grant, D., & Nightingale, L. (2012). Intervening after intimate partner violence. *Children's Mental Health Research Quarterly, 6*(4), 1–15. Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University.

Intimate partner violence and its impact on children

Personally, that time for me was horrible and if somebody just said it to me, "Is there something you want to talk about?" I probably would have told everything. My God, somebody noticed…

— Young person who had witnessed intimate partner violence[1]

Ideally, all children experience the adults in their lives interacting with respect and care. In reality, though, many children witness the most important adults in their life — their parents or caregivers — experiencing physical and emotional violence. Such violence is often termed *intimate partner violence* or IPV. Children's IPV exposure may be direct (e.g., seeing acts of physical aggression, hearing verbal abuse) or indirect (e.g., seeing a parent injured or upset, observing property damage, seeing police visits).[2]

Regardless of the form it takes, IPV harms children. Multiple studies have now confirmed what practitioners working with children have long perceived — exposed children experience high levels of distress, which can result in significant emotional and behavioural problems.[3] Exposure to IPV is therefore considered to be emotional abuse, a specific form of child maltreatment.[4]

How common is the problem?

IPV is typically underreported — to practitioners, to police, to child protection authorities and to researchers.[5] Therefore, obtaining accurate prevalence rates is challenging. Table 1 provides the best currently available North American estimates, based on four surveys of self-reported IPV experiences in large representative samples.

Regardless of the form it takes, intimate partner violence harms children.

What is intimate partner violence?

Intimate partner violence (or IPV) is the term used to describe physical and psychological violence occurring in the context of a marriage, common law or dating relationship. It can range from a single incident to repeated and ongoing abuse, and from verbal put-downs to severe assaults resulting in death.

Significant gender differences exist in terms of who perpetrates IPV, with data varying according to information source. In heterosexual relationships, police data typically suggest that many more men than women are perpetrators, whereas academic research data suggest near-equal rates.[6] However, there is little debate about gender differences in outcomes. Women are far more likely than men to be injured and to suffer other negative consequences, such as economic disadvantage and posttraumatic stress, as a result of IPV.[7, 8]

Table 1: Children's Exposure to Intimate Partner Violence (IPV)

Survey (Country, Year Conducted)	Informants	Time Frame	Adult IPV Victim Rate (Victims with Exposed Children)	Child IPV Exposure Rate	
				Adult Victim Report*	Child Self-Report
Canadian Violence Against Women Survey (Canada 1993)[9]	12,300 females ≥ 18 years	Ever by current partner	5.1% (33.2%)	1.7%	N/A
General Social Survey on Victimization (Canada 2009)[10, 11]	19,422 females + males ≥ 15 years	Past 5 years	6.2% (51.5%)	3.2%	N/A
National Survey of Children's Exposure to Violence (US 2008)[12]	4,549 females + males ≥ 17 years**	Past year	N/A	N/A	6.2%
		Lifetime	N/A	N/A	16.3%
National Violence Against Women Survey (US 1995–96)[9]	8,000 females ≥ 18 years	Ever by current partner	3.5% (40.2%)	1.4%	N/A

N/A Not assessed

* To derive crude estimates of child IPV exposure population rates from these studies, we multiplied the % of adult victims in the population by the % reporting that their children had witnessed IPV. The purpose was to enable comparisons with the other studies (reported in the final column) where children were asked directly about IPV exposure.

** Caregivers/parents reported for children < 10 years.

As Table 1 shows, child IPV exposure rates varied considerably depending on the time frame (lifetime versus one year) and depending on whether researchers talked directly with children. When children were asked, more than 16% (in the general population) admitted to being exposed.[12] However, when adult IPV victims were asked about their children's exposure, (calculated equivalent) rates were only 1% to 3%. These markedly lower rates may arise when adults do the reporting because they may not always realize — or may have difficulty acknowledging — that their children have witnessed IPV.

Keeping children safe

Recognizing that IPV exposure harms children,[4] governments have enacted child protection legislation in Canada and elsewhere to encourage — and sometimes compel — the reporting of this form of child maltreatment.[5] For example, IPV is covered under legislation in BC requiring that anyone who suspects that a child is in danger must notify child protection authorities.[13] (Additional information about reporting maltreatment is available in the *BC Handbook for Action on Child Abuse and Neglect for Service Providers*.)

According to the most recent Canadian data, nearly 30,000 substantiated cases of child maltreatment (or approximately 5 cases per 1,000 children in the population) were reported for 2008 involving IPV exposure as the primary form of maltreatment. IPV exposure is now the most common form of maltreatment substantiated in Canadian children, exceeding rates for neglect, physical abuse, other forms of emotional abuse and sexual abuse.[14]

Meanwhile, children's likelihood of having contact with protection agencies after IPV exposure varies considerably by age: cases involving younger children are reported and investigated significantly more frequently than those for older children.[4] Child protection authorities also appear to respond differently to IPV than to other forms of child maltreatment; IPV cases are less likely to remain "open" and families are therefore less likely to receive continuing services.[4]

When IPV is not the only adversity

Children exposed to IPV often experience other serious adversities at the same time. A large American study found that witnessing IPV was significantly associated not only with other forms of child maltreatment within the family, but also with victimization outside the family, including being bullied, being physically assaulted, witnessing community violence and experiencing property crime.[15] Children's IPV exposure is also closely linked to another important form of adversity — socio-economic disadvantage.[16] Clearly, the harm caused by IPV is multiplied when children experience these other adversities as well.

Beyond helping children cope after the fact, prevention is the best means of reducing the harm associated with intimate partner violence.

Helping children cope

Many children exposed to IPV nevertheless go on to cope well.[2] How does this occur? One longitudinal American study found two potential influences. One was positive parenting, including interactions that made children feel respected, accepted and supported. The other was peer support, including friendships with high levels of trust and positive communication.[17] Positive parenting was also significantly associated with fewer pregnancies in adolescence, while peer support was associated with fewer depressive symptoms and greater high-school completion rates. Meanwhile, both positive parenting and peer support were associated with lower rates of running away from home. These findings suggest that positive parenting and peer support can greatly help children cope, even in the face of serious adversities such as IPV.

Given the central importance of parenting to child well-being, helping children exposed to IPV means also helping their abused caregivers. The first step in this process usually involves securing needed resources, such as housing, to ensure safety. (The sidebar highlights BC and Canadian resources for both children and adults who have experienced IPV.) Next, parents often need support in dealing with the consequences of IPV, such as strategies for helping their children who may have secondary emotional and behavioural challenges. In the review article that follows, we examine four programs that aim to help children by helping their parents.

Beyond helping children cope after the fact, prevention is the best means of reducing the harm associated with IPV exposure. Our next issue of the *Quarterly* therefore focuses on intervening early — starting with preventing dating violence in adolescence.

Getting help

Beyond services to protect children, there are also services for adult victims of IPV, including housing, financial, medical and legal assistance. In BC, the Domestic Violence Helpline provides confidential assistance to both adults and adolescents. Their website (www.domesticviolencebc.ca) provides detailed information about existing programs and services, including legal assistance, transition homes and counselling. This site also provides information about VictimLink BC, including a 24-hour toll-free hotline (1-800-563-0808) available in multiple languages. Cross-Canada information is available at the National Clearinghouse on Family Violence, which can be accessed through the Public Health Agency of Canada website at www.phac-aspc.gc.ca/ncfv-cnivf/help-aide/index-eng.php.

How helping women helps their children

In responding to intimate partner violence, women's and children's safety must first be ensured.

Many communities offer programs to help women and children who have experienced intimate partner violence (IPV). Here, we assess these programs' outcomes.

To identify the relevant research, we conducted a systematic review using our usual methods (detailed in the Appendix). We found five randomized controlled trials (RCTs), described in 10 articles, that met our inclusion criteria. These five RCTs evaluated four different programs: *Advocacy,*[18] *Child-Parent Psychotherapy,*[19–21] *Nurse Case Management*[22, 23] and *Project Support* (evaluated in one original study plus one replication trial, referred to here as I[24, 25] and II[26, 27]). Table 2 summarizes the programs.

Each of the four programs focused on women who had experienced IPV. In addition to providing services to women, all but one program (*Nurse Case Management*) provided services to children as well. The programs were delivered to ethnically diverse populations in urban American communities. Most participating families were also economically disadvantaged.

Table 2: Program Characteristics

Name (Participants)*	Child Age (Gender)	Components	Comparison Condition
Advocacy[18] (80 women + children)	6–11 years (45% male)	*Women:* Trained university students taught strategies for accessing needed resources during twice-weekly home visits over 4 months *Children:* Leaders facilitated education on safety + emotions during weekly group sessions (location unspecified) over 2½ months	"No intervention"
Child-Parent Psychotherapy[19] (75 women + children)	3–5 years (48% male)	*Women + Children:* Psychotherapists encouraged positive child behaviours, positive parenting + trauma resolution during weekly clinic-based sessions over 11½ months**	Provision of support to access services + manage crises at monthly meetings†
Nurse Case Management[22] (260 women)	1–18 years (47% male)	*Women:* Nurses reviewed safety, provided information about additional services (legal, housing, job training) during 4 clinic-based sessions over 18 months	Provision of safety plan + list of relevant services at 1 meeting
Project Support I[24] (36 women + children)	4–9 years (72% male)	*Women:* Psychotherapists addressed resources, safety, parenting + problem-solving during weekly home visits for up to 8 months *Children:* Trained university students provided support + positive role modelling during weekly home visits for up to 8 months	Provision of support to access services at monthly meetings
Project Support II[26] (66 women + children)	4–9 years (50% male)	As above	As above

* Includes both intervention & comparison conditions.
** Individual sessions with mother were interspersed with joint mother-child sessions as clinically indicated.
† Face-to-face meetings were also provided on an as-needed basis.

Starting with safety

These four programs addressed safety concerns using a variety of approaches. With *Child-Parent Psychotherapy* and *Project Support,* women were excluded if they were still living with abusive partners, acknowledging the need to ensure basic safety before other interventions began. *Advocacy* attempted to reduce risk by delivering the program in homes, on the assumption that this approach might discourage contact by perpetrators. While portions of *Project Support* were similarly delivered in homes, providers also assessed and addressed any safety concerns that emerged as the program proceeded. Meanwhile, *Nurse Case Management* provided women with a brochure outlining safety information. All four programs also addressed women's abuse experiences. *Advocacy, Project Support* and *Nurse Case Management* provided practical supports, including information about personal options and assistance in obtaining basic services such as legal assistance. *Child-Parent Psychotherapy* directly addressed trauma issues — for both women and children — using talk therapy.

Three evaluations also looked at a particularly crucial question for children: did the program reduce maltreatment?

Addressing children's feelings and behaviour

Children were approached differently in each of the four programs. In *Advocacy,* they were educated about their safety and emotions. In *Project Support,* they received positive role modelling and support from trained university students. In *Child-Parent Psychotherapy,* psychotherapy was offered to children, together with their mothers, to help both deal with their IPV experiences, including managing challenging behaviours and emotions. Meanwhile, *Nurse Case Management* focused solely on mothers, aiming to reduce child behaviour problems by reducing mothers' stress.

Parenting was directly addressed in two programs. In *Project Support,* therapists taught parenting techniques to women whose children all had serious behaviour problems — either oppositional defiant or conduct disorders. In *Child-Parent Psychotherapy,* therapists helped women learn to avoid punitive parenting.

Intensity also varied across the four programs. The least intensive program — *Nurse Case Management* — provided mothers with four brief meetings of approximately 20 minutes each over 18 months. In contrast, the most intensive program — *Child-Parent Psychotherapy* — provided women and children with up to 50 hour-long joint therapy sessions. This was interspersed with individual sessions for women as needed, over $11^{1}/_{2}$ months.

Which programs worked best for children?

Children's outcomes were assessed at follow-up evaluations conducted between four and 24 months after program completion. Other than *Nurse Case Management,* all programs produced at least one beneficial outcome for children (see Table 3).

Table 3: Child Outcomes at Follow-Up

Program (Follow-Up)	Statistically Significant Findings	Non-significant Findings
Advocacy[18] (4 months)	↑ General self-confidence ↑ Athletic self-confidence ↑ Confidence in appearance ↓ Daily contact with perpetrator (11% vs. 27%)*	• Behaviour problems • Academic self-confidence • Social self-confidence • Ongoing IPV exposure • Other abuse by IPV perpetrator
Child-Parent Psychotherapy[20] (6 months)	↓ Behaviour problems (medium effect size)**	None
Nurse Case Management[22,23] (6 months)†	None	• Behavioural problems • Emotional problems
Project Support I[25] (24 months)	↓ Oppositional defiant or conduct disorders (15% vs. 53%)* ↓ Clinically significant behavioural problems (15% vs. 53%)* ↓ Clinically significant emotional problems (0% vs. 35%)* ↑ Happiness/social relationships ↓ Perpetration of physical abuse†† by mother (31% vs. 71%)*	None
Project Support II[26,27] (12 months)	↓ Behaviour problems (medium effect size)**	• Oppositional behaviours • Physical or emotional abuse by mother • Punitive parenting by mother • Inconsistent parenting by mother

* Percentages refer to intervention and control children, respectively.
** Effect sizes (small, medium or large) identify how much the outcomes made a meaningful "clinical" difference in children's lives.
† Study included 12-month follow-up data but with attrition levels that exceeded our inclusion criteria.[23]
†† Includes being hit with object, slapped, spanked, pushed, grabbed, shoved or having object thrown during previous 4 months.

Children's behaviour was assessed in all the evaluations, but only the two programs that specifically addressed parenting showed significant gains. *Child-Parent Psychotherapy* and *Project Support II* both led to significantly better average scores on measures of child behaviour problems. As well, *Project Support I* led to significantly fewer children experiencing extreme behaviour problems or ultimately meeting diagnostic criteria for oppositional defiant or conduct disorders (15% versus 53%).[25]

Children's emotional well-being was also assessed in three evaluations. *Project Support I* led to significantly fewer children experiencing severe emotional problems.[25] Children in this program also scored significantly better on measures of happiness and social relationships. Children in the *Advocacy* program also displayed emotional gains at follow-up but using measures that were less rigorous, e.g., athletic self-confidence.[18] Although children's emotional well-being was assessed only at program completion for *Child-Parent Psychotherapy,* this

assessment revealed an important outcome: intervention children were six times less likely to be diagnosed with posttraumatic stress disorder (PTSD) than comparison children (6% versus 36%).[20]

Three evaluations also looked at a particularly crucial question for children: did the program reduce maltreatment? For the *Advocacy* program, intervention children were nearly 2.5 times less likely to have daily contact with IPV perpetrators compared to controls (11% versus 27%).[18] The program did not, however, reduce ongoing exposure to IPV or other forms of maltreatment.[18] *Project Support,* meanwhile, focused on maltreatment by mothers. *Project Support I* children were over two times less likely to be physically abused by their mothers compared with controls (31% versus 71%).[25] However, this finding was not replicated in *Project Support II.*[26]

Which programs worked best for women?

Four evaluations also assessed whether women actually benefited, beyond improving their parenting. Only the *Advocacy* program led to gains — reducing women's depressive symptoms and improving their self-esteem. However, the program did not improve women's quality of life or social supports and, notably, did not reduce the recurrence of IPV. Similarly, *Project Support I* did not reduce the recurrence of IPV or the numbers of women returning to violent partners. *Project Support II* and *Child-Parent Psychotherapy* also failed to significantly reduce women's mental disorder symptoms. (The *Nurse Case Management* evaluation did not assess women's outcomes.)

Helping children by helping women

This review suggests that much can be done to help women help their children after they have experienced IPV. Three of the programs we examined (*Advocacy, Child-Parent Psychotherapy* and *Project Support*) produced significant benefits for children, while one (*Advocacy*) produced significant benefits for women as well. The positive child outcomes included reducing contact with IPV perpetrators and increasing self-confidence (*Advocacy*); reducing PTSD and behavioural problems (*Child-Parent Psychotherapy*); and reducing physical abuse by mothers (*Project Support I*) while also reducing emotional (*Project Support I*) and behavioural problems (*Project Support I* and *II*). Beyond improving women's parenting, *Advocacy* reduced depression and increased self-esteem. *Nurse Case Management* was the only program that failed to show any positive benefits for children and failed to measure any outcomes for women.

The three programs that produced beneficial outcomes shared several features. All three programs were relatively comprehensive: helping women access new resources (*Advocacy* and *Project Support*); providing parenting education (*Project Support* and *Child-Parent Psychotherapy*); and providing support directly to

This review suggests that much can be done to help women help their children after they have experienced intimate partner violence.

children (*Advocacy, Child-Parent Psychotherapy* and *Project Support*). As well, all three were relatively intensive — delivered at least weekly over periods ranging from four months (*Advocacy*) to eight months (*Project Support*) to 11 1/2 months (*Child-Parent Psychotherapy*).

Which program stands out?

Of the three programs with positive outcomes, *Project Support* stands out for three reasons. First, this program yielded the greatest number of significant benefits for children. In both trials, child behaviour problems were reduced. In the first trial, mothers' physical abuse and children's emotional problems were also reduced. Moreover, gains were sustained, particularly child behaviour disorder diagnoses, which were still reduced two years after the program had ended. These impressive findings suggest that many women can substantially improve their parenting, even under great stress, if they receive the right supports. Second, *Project Support* was particularly comprehensive, perhaps explaining the positive outcomes in that women and children received more supports overall. Third, investigators of *Project Support* conducted particularly thorough evaluations. In the first RCT, investigators tracked outcomes using rigorous (e.g., diagnostic) measures over the long term. They also conducted a replication trial.

Despite all the strengths of the program, it is important to recognize that *Project Support* was designed for a specific group — children who had witnessed IPV and who had developed severe behavioural problems. This specificity should be considered for any Canadian adaptations and evaluations of the program. As well, it would be useful for any future studies to evaluate economic outcomes as well as clinical ones.

Project Support *stood out as an effective program — being both comprehensive and intensive and yielding lasting benefits for children.*

Summing up

In responding to IPV, safety for women and children must first be ensured. Comprehensive safety planning includes providing women with economic, housing and legal assistance as well as considerable personal supports. After safety is assured, comprehensive interventions need to be offered to both women and children. *Project Support* stood out as an effective model based on this review — being both comprehensive and intensive and yielding lasting benefits for children. Canadian adaptations and evaluations of this program therefore appear to be warranted.

We predicated this review on identifying effective approaches for responding when children have been exposed to IPV. But preventing this exposure would be far preferable, given the high levels of distress, symptoms and impairment — in short, the *harm* — that IPV causes for children. Preventing IPV will be our focus in the next issue of the *Quarterly*.

What are the origins of evidence-based practices?

To the Editors:
Different terms are often used to describe research-based mental health interventions, including *evidence-based, evidence-informed* and *promising practices*. Are there commonly accepted definitions of these terms??

Barry Fulton
Kelowna, BC

All three terms originally derive from *evidence-based medicine,* a phrase coined in the 1990s to describe efforts to improve the care that physicians provided.[28, 29] Since then, evidence-based practice (EBP) has grown to become a movement and terms have multiplied, including the three mentioned.

Still, EBP's origins are informative. The movement arose from efforts to ensure that practitioners balanced "clinical judgment" with evidence derived from scientific research, thereby ensuring that treatment interventions did more good than harm. To assist practitioners, researchers launched initiatives like the Cochrane Collaboration to cull the burgeoning health literature, highlighting only those studies that were rigorous and worthy of informing practice.

EBP has since grown to encompass many other groups who provide care for individuals, including nurses, psychologists and social workers, in addition to physicians. Most recently, the movement has also encompassed policy-makers who oversee health and health care for populations. Most health practitioners and policy-makers now recognize that even if research evidence does not apply to *all* practice and policy decisions, all decisions should nevertheless be informed by the best available research evidence where it is available.[30]

The *Children's Mental Health Quarterly* directly addresses all these issues by: 1) using high standards to identify and cull the research evidence on children's mental health interventions; and 2) summarizing this evidence so practitioners and policy-makers may use it to inform their decision-making, and so families and young people may use it inform themselves about what works.

Most practitioners and policy-makers now recognize that even if research evidence does not apply to all decisions, all decisions should nevertheless be informed by the best available research evidence.

Contact Us

We hope you enjoy this issue.
We welcome your letters and suggestions for future topics. Please email them to chpc_quarterly@sfu.ca
or write to
Children's Health Policy Centre
Attn: Jen Barican
Faculty of Health Sciences
Simon Fraser University
Room 2435, 515 West Hastings St.
Vancouver, British Columbia
V6B 5K3

Research methods

For this review, we used systematic methods adapted from the Cochrane Collaboration[31] and from *Evidence-Based Mental Health*.[32] To identify high-quality evaluations, we first applied the following search strategy:

Table 4: Search Strategy

Sources	• Campbell Collaboration Library, CINAHL, Cochrane Database of Systematic Reviews, ERIC, Medline and PsycINFO
Search Terms	• Intimate partner violence, domestic violence, spouse, wife or partner abuse, battered women or females, treatment, prevention and intervention
Limits	• English-language articles published from 1992 to 2012 • Outcomes assessed in child participants 18 years or younger • Systematic review or randomized controlled trial (RCT) methods used

Articles describing systematic reviews and RCTs were first identified and retrieved. Then reference lists were scanned to identify further articles of relevance. Next we assessed all potentially relevant articles using the following inclusion criteria:

- Interventions for parents and/or children who had experienced intimate partner violence
- Clear descriptions of participant characteristics, settings and interventions
- Random assignment of participants to intervention and comparison groups at study outset
- Follow-up of three months or more (from the end of intervention)
- Maximum attrition rates of 20% at follow-up and/or use of intention-to-treat analysis
- At least one measure assessed children's mental health outcomes
- Reliability and validity of all primary measures were documented
- Levels of statistical significance were reported for outcome measures

Two different team members then assessed each retrieved article to ensure quality and relevance, reaching consensus regarding decisions about final inclusion in the review. Data were then extracted and summarized by the team.

For more information on our research methods, please contact

Jen Barican
chpc_quarterly@sfu.ca
Children's Health Policy Centre
Faculty of Health Sciences
Simon Fraser University
Room 2435, 515 West Hastings St.
Vancouver, British Columbia
V6B 5K3

References

BC government staff can access original articles from BC's Health and Human Services Library (www.health.gov.bc.ca/library/).

1. Buckley, H., Holt, S., & Whelan, S. (2007). Listen to me! Children's experiences of domestic violence. *Child Abuse Review, 16,* 296–310.
2. Graham-Bermann, S. A., & Howell, K. H. (2011). Child maltreatment in the context of intimate partner violence. In J. E. B. Myers (Ed.), *The APSAC handbook on child maltreatment* (3rd ed., pp. 167–180). Thousand Oaks, CA: Sage.
3. Evans, S. E., Davies, C., & DiLillo, D. (2008). Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. *Aggression and Violent Behavior, 13,* 131–140.
4. Black, T., Trocme, N., Fallon, B., & Maclaurin, B. (2008). The Canadian child welfare system response to exposure to domestic violence investigations. *Child Abuse and Neglect, 32,* 393–404.
5. Cross, T. P., Mathews, B., Tonmyr, L., Scott, D., & Ouimet, C. (2012). Child welfare policy and practice on children's exposure to domestic violence. *Child Abuse and Neglect, 36,* 210–216.
6. Ver Steegh, N., & Dalton, C. (2008). Report from the Wingspread Conference on Domestic Violence and Family Courts. *Family Court Review, 46,* 454–475.
7. Saunders, D. G. (2002). Are physical assaults by wives and girlfriends a major social problem? A review of the literature. *Violence Against Women, 8,* 1424–1448.
8. Caldwell, J. E., Swan, S. C., & Woodbrown, V. D. (2012). Gender differences in intimate partner violence outcomes. *Psychology of Violence, 2,* 42–57.
9. Thompson, M. P., Saltzman, L. E., & Johnson, H. (2003). A comparison of risk factors for intimate partner violence–related injury across two national surveys on violence against women. *Violence Against Women, 9,* 438–457.
10. Statistics Canada. (2011). *Family violence in Canada: A statistical profile*. Ottawa, ON: Statistics Canada.
11. Sinha, M. (2012). *Family violence in Canada: A statistical profile, 2010*. Ottawa, ON: Statistics Canada.
12. Finkelhor, D., Turner, H., Ormrod, R., & Hamby, S. L. (2009). Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics, 124,* 1411–1423.
13. Child, Family and Community Service Act [RSBC 1996]. Chap. 46. (2012). Retrieved May 3, 2012, from http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96046_01
14. Public Health Agency of Canada. (2010). *Canadian incidence study of reported child abuse and neglect 2008: Major findings*. Ottawa, ON: Public Health Agency of Canada.
15. Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2010). The overlap of witnessing partner violence with child maltreatment and other victimizations in a nationally representative survey of youth. *Child Abuse and Neglect, 34,* 734–741.
16. Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 116–122.
17. Tajima, E. A., Herrenkohl, T. I., Moylan, C. A., & Derr, A. S. (2011). Moderating the effects of childhood exposure to intimate partner violence: The roles of parenting characteristics and adolescent peer support. *Journal of Research on Adolescence, 21,* 376–394.
18. Sullivan, C. M., Bybee, D. I., & Allen, N. E. (2002). Findings from a community-based program for battered women and their children. *Journal of Interpersonal Violence, 17,* 915–936.
19. Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44,* 1241–1248.

20. Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45,* 913–918.
21. Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect, 35,* 504–513.
22. McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2005). Behaviors of children following a randomized controlled treatment program for their abused mothers. *Issues in Comprehensive Pediatric Nursing, 28,* 195–211.
23. McFarlane, J. M., Groff, J. Y., O'Brien J, A., & Watson, K. (2005). Behaviors of children exposed to intimate partner violence before and 1 year after a treatment program for their mother. *Applied Nursing Research, 18,* 7–12.
24. Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank, P. R., Stephens, N., et al. (2001). Reducing conduct problems among children of battered women. *Journal of Consulting and Clinical Psychology, 69,* 774–785.
25. McDonald, R., Jouriles, E. N., & Skopp, N. A. (2006). Reducing conduct problems among children brought to women's shelters: Intervention effects 24 months following termination of services. *Journal of Family Psychology, 20,* 127–136.
26. Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing conduct problems among children exposed to intimate partner violence: A randomized clinical trial examining effects of Project Support. *Journal of Consulting and Clinical Psychology, 77,* 705–717.
27. McDonald, R., Dodson, M. C., Rosenfield, D., & Jouriles, E. N. (2011). Effects of a parenting intervention on features of psychopathy in children. *Journal of Abnormal Child Psychology, 39,* 1013–1023.
28. Ciliska, D., Thomas, H., & Buffett, C. (2010). *An introduction to evidence-informed public health and a compendium of critical appraisal tools for public health practice*. Hamilton, ON: National Collaborating Centre for Methods and Tools, School of Nursing, McMaster University.
29. Claridge, J. A., & Fabian, T. C. (2005). History and development of evidence-based medicine. *World Journal of Surgery, 29,* 547–553.
30. Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. *Evidence-Based Mental Health, 8,* 60–62.
31. Higgins, J. P. T., & Green, S. (2011). *Cochrane handbook for systematic reviews of interventions version 5.1.0 [updated March 2011].* Retrieved August 20, 2012, from http://www.cochrane-handbook.org
32. Purpose and procedure. (2012). *Evidence-Based Mental Health.* Retrieved August 11, 2012, from http://ebmh.bmj.com/content/15/2/e3.full?sid=9a709906-a9ed-4144-bd35-297c433bd2ec

Links to Past Issues

2012 / Volume 6

3 – How Can Foster Care Help Vulnerable Children?
2 – Treating Anxiety Disorders
1 – Preventing Problematic Anxiety

2011 / Volume 5

4 - Early Child Development and Mental Health
3 - Helping Children Overcome Trauma
2 - Preventing Prenatal Alcohol Exposure
1 - Nurse-Family Partnership and Children's Mental Health

2010 / Volume 4

4 - Addressing Parental Depression
3 - Treating Substance Abuse in Children and Youth
2 - Preventing Substance Abuse in Children and Youth
1 - The Mental Health Implications of Childhood Obesity

2009 / Volume 3

4 - Preventing Suicide in Children and Youth
3 - Understanding and Treating Psychosis in Young People
2 - Preventing and Treating Child Maltreatment
1 - The Economics of Children's Mental Health

2008 / Volume 2

4 - Addressing Bullying Behaviour in Children
3 - Diagnosing and Treating Childhood Bipolar Disorder
2 - Preventing and Treating Childhood Depression
1 - Building Children's Resilience

2007 / Volume 1

4 - Addressing Attention Problems in Children
3 - Children's Emotional Wellbeing
2 - Children's Behavioural Wellbeing
1 - Prevention of Mental Disorders