

# In plain sight: The evidence from children exposed to domestic abuse

CAADA Research Report

February 2014



## Insights into domestic abuse

# 2



One third disclose mental health issues and/or substance misuse



60% feel to blame and 52% have behavioural problems



Only 6% receive support to address abusive behaviour



Only 42% receive support from a specialist domestic abuse service



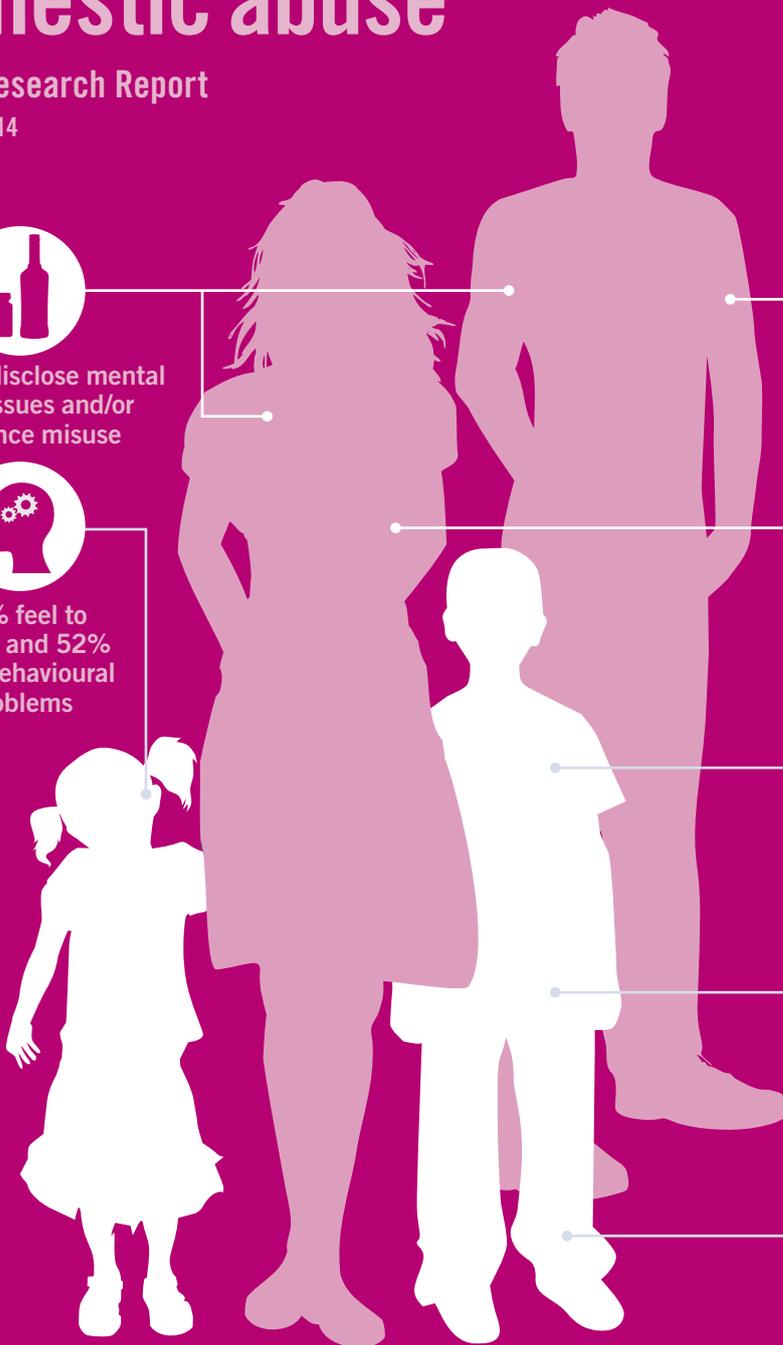
A quarter exhibit abusive behaviour



62% exposed to domestic abuse are also directly harmed



Only half (54%) are known to children's social care



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## About this report

This research report should be read alongside the recommendations in our policy report, 'In plain sight: effective help for children exposed to domestic abuse' and the full Children's Insights Dataset 2011–13, all available from [www.caada.org.uk](http://www.caada.org.uk)

# Summary of research findings



## What children are living with [pp.8–15]

Too many children are living with domestic abuse. Almost all (97%) of the children in our dataset were exposed to domestic abuse, of which almost half (46%) was severe domestic abuse.

- These experiences were not new. Some 42% of mothers and 30% of fathers had experienced or perpetrated domestic abuse in a previous relationship.
- We found a major overlap between domestic abuse and direct harm of children. Two thirds (62%) of the children exposed to domestic abuse were also directly harmed, most often physically or emotionally abused, or neglected. As a proportion of the whole dataset, this means that 28% of children were physically harmed, 58% emotionally abused and 18% neglected.
- In this dataset, the perpetrator of the domestic abuse was very often also the perpetrator of direct harm to the child. In 91% of cases a perpetrator was the same in both types of abuse: of these matched cases, predominantly the father (64%) or mother's male partner (25%).
- These children's families were vulnerable in multiple ways. Our data show a clear co-occurrence between the 'toxic trio' risk factors of domestic abuse, substance misuse (alcohol and/or drugs) and parental mental ill health. Nearly a third of mothers (31%) and a third of fathers (32%) in these families experiencing domestic abuse disclosed either mental health problems, substance misuse, or both.
- Children were suffering multiple physical and mental health consequences as a result of exposure to domestic abuse. Amongst other effects, over half (52%) had behavioural problems, over a third (39%) had difficulties adjusting at school and nearly two thirds (60%) felt responsible or to blame for negative events.
- A quarter (25%) of children exposed to domestic abuse, equally boys and girls, exhibited abusive behaviours, mostly towards their mother (62%) or sibling (52%) and rarely towards their father or mother's male partner, despite these individuals perpetrating the abuse in most of these cases. The children were most commonly physically abusive, in 82% of cases.
- The highest rates of abusive behaviour were amongst 15 to 17 year old children.
- Those children showing abusive behaviour were more likely to have been victims of more severe direct harm, including neglect, physical abuse and emotional abuse.
- Children were more likely to display abusive behaviour after their exposure to domestic abuse had ended, and were less likely to do so whilst still exposed to abuse.

## Identifying children [pp.16–17]

- Only half (54%) the children exposed to domestic abuse – and two thirds (63%) of those exposed to severe domestic abuse – were known to statutory children’s social care prior to intake to the specialist service.
  - The cases which were previously known to children’s social care were slightly more likely to involve severe direct harm across a range of categories. They also tended to be younger children.
  - However, between 8% and 26% of cases involving severe direct harm to children across different abuse types were still not known to children’s social care. This rose to 25% to 35% for children across all severity levels.
  - Of those not previously known to children’s social care, 48% were known to at least one other agency and 52% were not known to any other agency. As a proportion of the overall dataset, this means that 20% of children were not previously known either to children’s social care or any other agency. At least 80% of these children were previously known either to children’s social care or to another agency: they were in plain sight.
- were assessed by the children’s caseworkers as able to show insight and care towards their children in 79% of cases. Amongst fathers this figure was 19%.

## Providing effective help [pp.18–22]

- We found a relationship between cessation of domestic abuse and cessation of direct harm perpetrated against the child in these cases. This suggests that ending domestic abuse should be in the core interests of all those responsible for safeguarding children.
  - Our data highlight some of the protective factors parents bring, as well as the risks they can pose. Even though mothers in this sample were commonly the victims of domestic abuse, they
- Latest data from CAADA’s adult Insights National Dataset 2012–13 (forthcoming) for adult victims of abuse show that 69% of domestic abuse ceased at the point of case closure after support from an IDVA. Yet, in this dataset, only 42% of the children’s parents who were victims of domestic abuse, and 6% who were perpetrators, received support from a specialist domestic abuse service.
  - Evidence from the Early Intervention Foundation shows that parenting programmes can be a critical form of early intervention and help for families experiencing domestic abuse. Yet only 6% of parents in our dataset accessed any form of parenting support.
  - Specialist services for children exposed to domestic abuse substantially improved their immediate health, safety and wellbeing outcomes. Following support, negative impacts for the children were reduced, and their positive outcomes increased, by half to two thirds across a range of key indicators of health, safety and achievement.
  - Some of these children are likely to require longer-term therapeutic support to recover from their experiences. Only 9% of children were receiving support from Child and Adolescent Mental Health Services (CAMHS) at intake to the children’s service. By exit, a further 2% of children had been engaged with CAMHS. This seems low, given what those children are living with and the impacts we see in these data.
  - Following support from these specialist services, children exhibiting abusive behaviour fell from 25% of cases at intake to 7% at exit.

# Context and research methods

## Introduction

- 0.1 An estimated 130,000 children in the UK live in households with high-risk domestic abuse; that is, where there is a significant risk of harm or death.<sup>1</sup> And those are only the tip of the iceberg: many thousands more live daily with lower level domestic abuse. A strong relationship has already been shown between the maltreatment of children in the home and domestic abuse of a parent. For instance, Brandon *et al.* (2011) showed domestic abuse to be a factor in two thirds of Serious Case Reviews where a child has died.<sup>2</sup>
- 0.2 In January 2014, the Early Intervention Foundation published a systematic review of literature and research on domestic abuse and children at risk. In a review of multiple studies of child protection cases, it found that domestic abuse was a factor in up to 65% and no less than 26% of families. Three of the seven studies had a prevalence rate of over 50% and another three had a prevalence rate of over a third.<sup>3</sup>
- 0.3 This research report investigates the profile and needs of children living with domestic abuse. We publish new primary data on these children which highlights the very real overlap of child maltreatment and domestic abuse, maps in greater detail some of the serious and wide-ranging impacts of domestic abuse on children, but also points to effective interventions and evidences the way in which specialist services support children and parents to significantly improved safety and wellbeing. We also identify risk factors which we recommend should inform risk assessment and awareness training for all practitioners working with children.
- 0.4 This report should be read alongside CAADA's 2014 policy report, 'In plain sight: effective help for children exposed to domestic abuse', which makes recommendations to policy makers and commissioners about how to act on this new data

to support vulnerable children. At the same time, we also publish the first full Children's Insights dataset, and our second adult National Insights Dataset 2012–13 (forthcoming), both available for download from [www.caada.org.uk](http://www.caada.org.uk).

## Context: domestic abuse and children

### Research findings

- 0.5 Findings from the NSPCC prevalence study (Radford *et al.*, 2011), 'Child abuse and neglect in the UK today', show that 25% of children are exposed to domestic abuse between adults in their homes at some point in childhood (up to age 18).<sup>4</sup> Whilst this reflects domestic abuse of all risk levels, the same study found that 6% of all children had been exposed to severe domestic abuse at some point in their childhood.<sup>5</sup>
- 0.6 The literature shows that children can experience domestic abuse in different ways. They may be present and witness or hear the abuse, or see their parent's injuries afterwards (NSPCC). A meta-analysis of 118 studies found that 63% of children witnessing domestic abuse fared more poorly on psycho-social measures than those who hadn't (Kitzmann, Gaylord, Holt & Kenny (2003), cited in Early Intervention Foundation, (2014)).<sup>6</sup>
- 0.7 Humphreys (2006) has shown that children who are exposed to the domestic abuse of a parent often have greater behavioural and emotional problems compared to other children, both internal (such as depression and anxiety) and external (such as aggression or anti-social behaviour).<sup>7</sup> Neurological studies have shown that exposure to domestic violence and/or direct abuse can also affect the way the brain works. For example, McCrory *et al.* (2011)

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1. CAADA (2012), CAADA Insights 1: 'A place of greater safety'. Bristol: CAADA.
2. Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2011), 'New learning from serious case reviews: a two year report for 2009–11'. London: Department for Education.
3. Early Intervention Foundation (2014), 'Domestic violence and abuse review'. London: Early Intervention Foundation. pp.42–43.

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4. Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011), 'Child abuse and neglect in the UK today'. London: National Society for the Prevention of Cruelty to Children.
5. Defined by the NSPCC study as witnessing a parent being kicked, choked or beaten up by the other parent.
6. Kitzmann, K., Gaylord, N., Holt, A. and Kenny, E. (2003), 'Child witnesses to domestic violence: a meta-analytic review'. *Journal of Consulting and Clinical Psychology*, 71( 2), pp.339–352. DOI: 10.1037/0022-006X.71.2.339
7. Humphreys, C. (2006) 'Relevant evidence for practice'. In C. Humphreys and N. Stanley, eds. (2006), 'Domestic violence and child protection: Directions for good practice'. London: Jessica Kingsley.

found that exposed children displayed greater neural activity of the amygdala and anterior insula in response to threat stimuli.<sup>8</sup> Importantly, the authors suggest that this pattern of response may make children (and later adults) more vulnerable to mental health issues such as anxiety. In addition, Tomoda, Polcari, Anderson and Teicher (2012) found that there was a reduction in the thickness and volume of grey matter associated with the visual cortex in adults exposed to domestic abuse as children. The authors of the latter study suggest that brain areas which process sensory information associated with domestic abuse might be modified by this experience.<sup>9</sup>

- 0.8** The literature shows that children who experience the domestic abuse of a parent are also likely to be at risk of other types of abuse. Our data echoes the literature: two thirds of the children in our sample had been directly harmed themselves in addition to being exposed to abuse of a parent. Stanley, Miller, Richardson, Thomson and Thomson (2009) showed that in 50% of cases, domestic abuse continues even after parental separation, often during contact visits.<sup>10</sup>
- 0.9** Previous literature has described the tensions between the child protection and domestic abuse systems and approaches (or 'planets'; Hester, 2011).<sup>11</sup> In particular this focuses on the emphasis the child protection system places on the mother's role (and often perceived inability) in protecting children from domestic abuse, often ignoring the equal responsibility of fathers. Child protection guidance advises that any family where there is domestic abuse should be referred for an 'early help' assessment to determine whether there should be intervention by children's social care.<sup>12</sup> Ashley (2011) found a lack of assessment and information about the parenting capacity of 61% of domestically abusive fathers.<sup>13</sup>
- 0.10** Previous studies have highlighted barriers to effective intervention with children living with domestic abuse, including a lack of confidence amongst professionals – especially non-social care practitioners – working with

children to ask about domestic abuse and to know what to do with a disclosure, and a lack of common universal training standard or knowledge requirement for early intervention practitioners (see EIF 2014 for a review).

- 0.11** Other studies have examined the effects of domestic abuse on children from the point of view of seeking to identify domestic abuse in the family of a child seen as at risk and have made recommendations accordingly (e.g. screening policies for frontline workers, training for those working with young people; (Hester (2006), Magen, Conroy and Tufo (2000)).<sup>14</sup> Our data shows the importance of identifying and providing services for children of parents identified through and accessing adult domestic abuse services.

### Policy and legislation

- 0.12** Whilst research has consistently shown a relationship between domestic abuse and children, a number of recent policy changes have highlighted the link. The change in Government definition of domestic abuse to include children aged 16–18 as victims has been in part in response to persistent lobbying by the domestic abuse sector that this group is at risk, supported by research findings about the extent of teen relationship abuse.<sup>15</sup>
- 0.13** The Allen Review in 2011 built cross-party consensus around the importance of early intervention.<sup>16</sup> The Early Intervention Foundation, established to build on the work of the Allen Review, has recently highlighted domestic abuse to be one of the major risks to child wellbeing and opportunities for early intervention.<sup>17</sup>
- 0.14** The Munro Review of Child Protection (2011) emphasised the importance of having a child-centred approach to supporting children at risk, and called for better joint working and a consistent offer of 'early help' for all children in need.<sup>18</sup> The Government's statutory guidance, 'Working together to safeguard children' (revised 2013) similarly emphasised the importance of a 'child-centred and co-ordinated approach to safeguarding', based on the needs and views of children.<sup>19</sup>

8. McCrory, E., De Brito, S., Sebastian, C., Mechelli, A., Bird, G., Kelly, P. and Viding, E. (2011), 'Heightened neural reactivity to threat in child victims of family violence'. *Current Biology*, 21(23), pp.R947–R948. DOI: 10.1016/j.cub.2011.10.015

9. Tomoda, A., Polcari, A., Anderson, C.M. and Teicher, M.H. (2012), 'Reduced visual cortex gray matter volume and thickness in young adults who witnessed domestic violence during childhood'. *PLoS ONE*, 7(12), e52528. DOI:10.1371/journal.pone.0052528

10. Stanley, N., Miller, P., Richardson, H., Thomson, F. and Thomson, G. (2009), 'Children and families experiencing domestic violence: Police and children's social services' responses'. London: National Society for the Prevention of Cruelty to Children.

11. Hester, M. (2011), 'The three planet model: Towards an understanding of contradictions in approaches to women and children's safety in contexts of domestic violence'. *British Journal of Social Work*, 41(5), pp. 837–853.

12. Department for Education (2013), 'Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children'. London: Department for Education.

13. Ashley, C. ed., (2011), 'Working with risky fathers: Fathers matter volume 3: Research findings on working with domestically abusive fathers and their involvement with children's social care services'. London: Family Rights Group.

14. Hester, M. (2006), 'Asking about domestic violence – Implications for practice'. In C. Humphreys and N. Stanley, eds. (2006), 'Domestic violence and child protection: Directions for good practice'. London: Jessica Kingsley.

Magen, R., Conroy, K., and Tufo, A. (2000), 'Domestic violence in child welfare preventative services: Results from an intake screening questionnaire'. *Children and Youth Services Review*, 22, pp.174–251.

15. For instance, Wood, M., Barter, C. and Berridge, D. (2011), 'Standing on my own two feet: Disadvantaged teenagers, intimate partner violence and coercive control'. London: National Society for the Prevention of Cruelty to Children.

16. Allen, G. (2011), 'Early Intervention: Smart Investment, Massive Savings: The second independent report to Her Majesty's Government'. London: HMSO.

17. Early Intervention Foundation (2014), 'Domestic violence and abuse review'. London: Early Intervention Foundation.

18. Department for Education (2011), 'The Munro review of child protection final report: A child-centred system'. London: HMSO.

19. Department for Education (2013), 'Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children'. London: Department for Education. p.8.

**0.15** The Government's current programme to turn around 120,000 'troubled families' (to be extended to a further 400,000 in 2015) includes domestic abuse as a discretionary criterion for inclusion on the programme. This has already been adopted by approximately two-thirds of areas in recognition of its significance as a risk factor in many families.

**0.16** Alongside this policy framework sit a number of statutory duties to address the harm to children from domestic abuse, principally:

- Children Act 1989 and Children Act 2004 set out the legal framework for the protection of children and establish the key principle that the welfare of the child is the paramount consideration.
- Section 120 of the Adoption and Children Act 2002 extends the legal definition of 'significant harm' to children to include the harm caused by witnessing or overhearing abuse of another, especially in a context of domestic violence.
- Government statutory guidance, Working Together to Safeguard Children (revised April 2013) sets out the framework for provision of children's services, responsibilities and accountability through Local Safeguarding Children Boards (LSCBs).
- Witnessing domestic abuse is also recognised as harm in the Family Homes and Domestic Violence (Northern Ireland) Order 1998 and in the Family Law (Scotland) Act 2006.

## Questions remaining

**0.17** Despite this substantial evidence showing the harm to children from domestic abuse, and the increased risk of direct harm, there is a lack of detailed, up-to-date and consistent data from children about their experiences of living with domestic abuse. This report draws on CAADA's pioneering new Children's Insights dataset to show what it is like for children living with domestic abuse and how it affects them. Importantly, this is a live, ongoing dataset: therefore, we will be able to follow up these findings in the future. The findings challenge everyone to take action. We make recommendations about what to do in our policy report, 'In plain sight: effective help for children exposed to domestic abuse'.<sup>20</sup>

## Research questions, the data and methods

### Research questions

**0.18** This report addresses three main questions and draws policy and practice recommendations from them:

- What impact does exposure to domestic abuse of a parent/s have on a child's health, safety, wellbeing and behaviour?
- What might be protective and risk factors for the health, safety and wellbeing of children exposed to domestic abuse?
- Do specialist interventions for children exposed to domestic abuse improve their outcomes?

### About CAADA's Children's Insights dataset

**0.19** Children's Insights is an outcomes measurement tool which works through simple collection of data on a child and family's circumstances, health, wellbeing and safety indicators and risks at intake and exit from a specialist children's service. Data are collected on each child through caseworker assessments, analysed by CAADA and outcomes, changes in health and wellbeing, and changes in abuse levels are reported back to the service. CAADA now holds a live, anonymised aggregate dataset on hundreds of children experiencing domestic abuse and supported by such specialist services.

**0.20** Children's Insights has been piloted and tested in four services supporting children living with domestic abuse: Domestic Violence and Abuse Service (DV&AS), Stop Abuse For Everyone (SAFE) and North Devon Against Domestic Abuse (NDADA) in Devon, and Empowerment domestic abuse service in Blackpool.

**0.21** Data were collected over a 30 month period from February 2011 to September 2013. All four services support children who are currently exposed to, or have in the past been exposed to, abuse in the home. They work with children exposed to all risk levels of abuse. Specialist workers in these projects provide interventions to improve the children's safety and wellbeing, including creating safety plans, liaising with health, education and criminal justice agencies, and arranging access to financial and other practical support. They support the children through one-to-one and group work sessions to address issues of self-esteem, manage emotions and feelings of blame and responsibility. The sessions also aim to improve children's understanding of abusive behaviour, healthy relationships and conflict resolution.

**0.22** This report is the first publication from CAADA's Children's Insights dataset and draws on the complete dataset of 877 unique individual cases at intake and 516 matched cases at exit, drawn from the four services between February 2011 and September 2013. The data collected by practitioners is supplemented by a form which children are supported

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20. CAADA (2014), 'In plain sight: effective help for children exposed to domestic abuse'. Bristol: CAADA.

to fill in themselves at intake and at exit. This report also draws on the 331 forms completed by children at intake and 131 matched forms at exit. Children over 7 years old were asked to complete the form, and consent was obtained from the child (where over 16) or parent and child (under 16). Caseworkers were able to help children read the questions but were asked not to answer for them. The full dataset snapshot containing both the caseworkers' and children's forms as at September 2013 is published as an appendix to this report on CAADA's website. The cases in this dataset involve children between 0 and 18 years old, with the majority (69%) between 5 and 13 years old.

- 0.23** We are publishing this to make it available as a resource for other researchers and policy makers. Key data and findings are presented and discussed on pages 8 to 22 of this report, and in the accompanying policy report, 'In plain sight: effective help for children exposed to domestic abuse' (available from [www.caada.org.uk](http://www.caada.org.uk)).

## Methods

- 0.24** A repeated measures (pre- to post-intervention) design was implemented: four forms were provided for each of a child's engagements with a local service. Firstly, an 'Intake form' to be completed by the specialist children's practitioner and an 'About you intake form' to be completed by the child. These forms were to be completed within the first three contacts with the child. Secondly, an 'Exit form' to be completed by the practitioner and an 'About you exit form' to be completed by the child. These forms were to be completed at planned case closure. If a client disengaged unexpectedly from a service then the 'Exit form' was completed with as much information about the current status of the case as possible and the status of the case was indicated on the form.
- 0.25** Specific ethical approval was not required for this project as this work had no bearing on the intervention a child might receive and all data collected would be collected as part of standard case-tracking. Consent to have data recorded for research monitoring purposes was obtained from the parent of the child and if appropriate from the child themselves. With respect to the two forms that the children completed themselves, if a child did not want to complete the form, they did not have to.
- 0.26** Data from forms were entered into Excel manually. If responses were found that were 'out of range' or key case tracking information was missing, every effort was made to contact the local service and replace these omissions. However, there were a number of potential sources of missing data in this pilot project. Forms may have been submitted that had valid case tracking information but may have had a few questions missed that were not completed despite efforts to find information. There was also the possibility that at the time that this report was being created, cases were ongoing. Therefore, there are more intake than

exit forms. There were also cases where practitioners had completed intake and exit forms but children had chosen not to complete 'About you' forms. Considering this, we have chosen to present data in this report that is not from matching sets of forms or perfectly complete forms in order to preserve as much usable data as possible. Missing data has been indicated where relevant in the report and in full in the data appendix.

- 0.27** Duplicates were identified using a unique identifier that was assigned to each set of four forms received and removed manually case-wise from the dataset. In some cases, a child returned to the service for assistance after their case was initially closed. In this case, a new set of forms was completed and a new unique identifier was assigned. We also collected the local case identifier on our forms. Therefore, by highlighting duplicate local case identifiers that had different unique identifiers, we were able to report a repeat rate and then only include the latest set of completed forms in the aggregate dataset. This procedure was completed so that individual differences were not misrepresented in the overall dataset. The vast majority of the data collected was categorical in nature; therefore, Chi-square analysis was conducted where the relationship between variables was of interest.

## KEY FINDINGS

# What children are living with

### The nature of the domestic abuse at home

- 1.1 As we would expect from the sample, almost all of the children in our dataset had witnessed domestic abuse at home. Of the 877 cases at intake, 97% of the children had been exposed to the domestic abuse of a parent, of which 46% ( $n=389$ ) was assessed to be severe domestic abuse (risk of serious harm or death).<sup>21</sup> See figure 1 for the full severity profile. Nearly all (95%) of these children were at home when the domestic abuse took place.
- 1.2 In terms of who was doing what, in 96% of all cases in the dataset the victim of the domestic abuse was the child's mother (see figure 2); in 73% of cases the perpetrator of the domestic abuse was their father and in 29% their mother's male partner<sup>22</sup> (see figure 3).
- 1.3 The data show that these children are far from being passive bystanders: many were caught in the crossfire. A fifth (18%) had been injured as a result of abuse of a parent, almost half (45%) had tried to intervene to stop the abuse, and 10% had called the emergency services. See the Children's Insights Dataset 2011–13 for the full range of these impacts.

### 'Toxic Trio': Co-occurrence of domestic abuse, parental mental ill health & drug/alcohol abuse

- 1.4 Our data (see figure 4) show a range of additional vulnerabilities present in the family in these cases, including substantial rates of disclosed mental health problems amongst both parents (25% of all mothers and 17% of all fathers), substance misuse, including alcohol and/or drugs (13% of all mothers, 25% of all fathers), antisocial or criminal behaviour (7% of all mothers, 28% of all fathers) and experience as a victim or perpetrator of domestic abuse in a previous relationship (42% of mothers, 30% of fathers). Additionally, 14% of families were homeless.

21. 2% were not exposed to abuse, and 1% were missing data.

22. In indicating perpetrator, case workers are asked to tick all that apply; so not all percentages total 100.

- 1.5 Given their presence as additional risk factors in Serious Case Reviews, we looked at the presence of one or both of: parental mental ill-health and substance misuse in these families alongside the domestic abuse. Our data show a clear co-occurrence between the 'toxic trio' risk factors of domestic abuse, substance misuse (alcohol and/or drugs) and parental mental ill health. Nearly a third of mothers (31%) and a third of fathers (32%) had disclosed either mental health problems, substance misuse, or both.
- 1.6 These rates are slightly lower, but broadly aligned with, disclosure rates in our forthcoming adult National Insights Dataset 2012–13, in which victims of domestic abuse disclose mental health concerns in 30% of cases, and substance misuse (alcohol and/or drugs) in 19% of cases.<sup>23</sup> These rates are likely to be under-reported, perhaps significantly, given that parents are asked the question at a point which may be the first time they have sought help: we know that longer term rates of mental ill health amongst domestic abuse victims tend to be higher.<sup>24</sup> Also consistent with our data, a recent report by the NSPCC (Radford *et al.*, 2011) on Serious Case Reviews where domestic abuse was present found that a number of factors increased the risk to children in domestic abuse families, including:

- Presence of parental mental health problems (including suicidal thoughts and/or threats to kill from men, and depression, low self-esteem or anxiety for women)
- Parental substance abuse, in particular alcohol abuse
- History of violence, either against previous partners or other adults or as young offenders.<sup>25</sup>

### Serious health and wellbeing consequences for children

- 1.7 Our data show that children exposed to domestic abuse suffer a range of adverse physical and mental health, social, wellbeing and behavioural effects, consistent with the literature on the impact on children of exposure to domestic abuse.<sup>26</sup> The child's safety, health, physical and psychological wellbeing was assessed by the specialist children's caseworkers at intake, and again at exit, from the service. In addition, children themselves reported on similar measures at intake and exit.

23. CAADA (2014), Adult Insights National Dataset 2012–13 (forthcoming).

24. See, for instance, World Health Organisation (2013), 'Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence'. Geneva: World Health Organisation.

25. Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. and Collishaw, S. (2011), 'Child abuse and neglect in the UK today'. London: National Society for the Prevention of Cruelty to Children.

26. See Early Intervention Foundation (2014), 'Domestic violence and abuse review'. London: Early Intervention Foundation.

Figure 1: Severity of domestic abuse children were exposed to (% of cases)

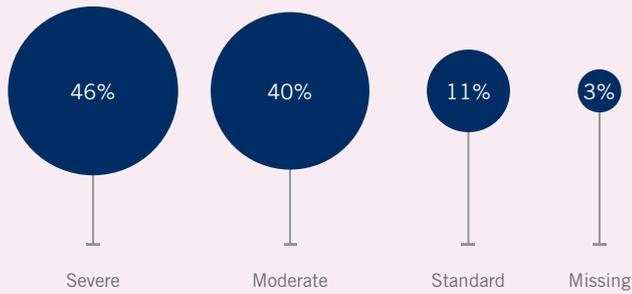


Figure 2: Victims of the domestic abuse (% of all cases, top 5 categories)

See Children's Insights Dataset 2011-13 for all categories.

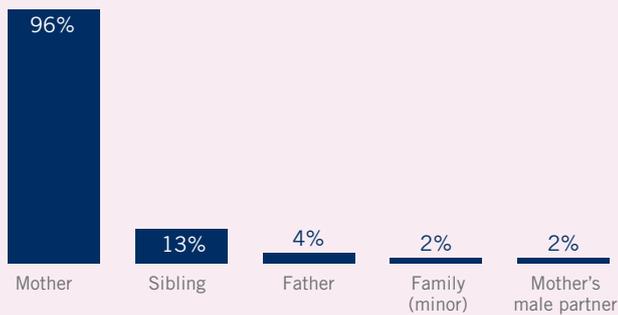


Figure 3: Perpetrators of the domestic abuse (% of all cases, top 5 categories)

See Children's Insights Dataset 2011-13 for all categories.

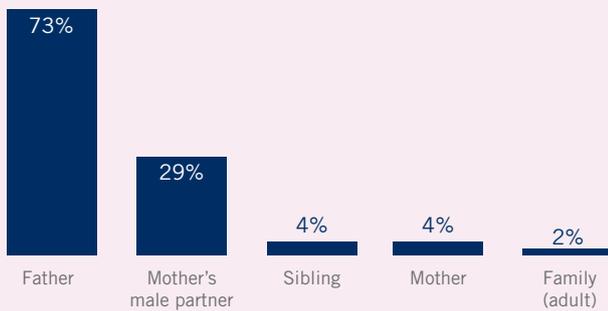


Figure 4: Additional vulnerabilities in family



Figure 5: Impact on children's safety at intake and exit, as measured by children's caseworkers

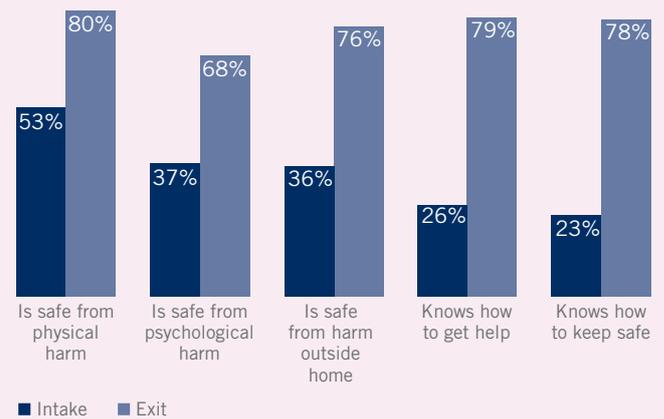
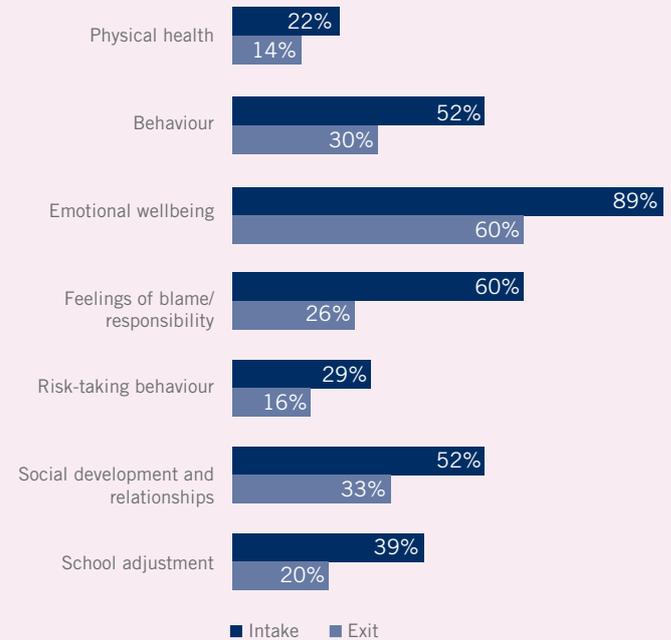


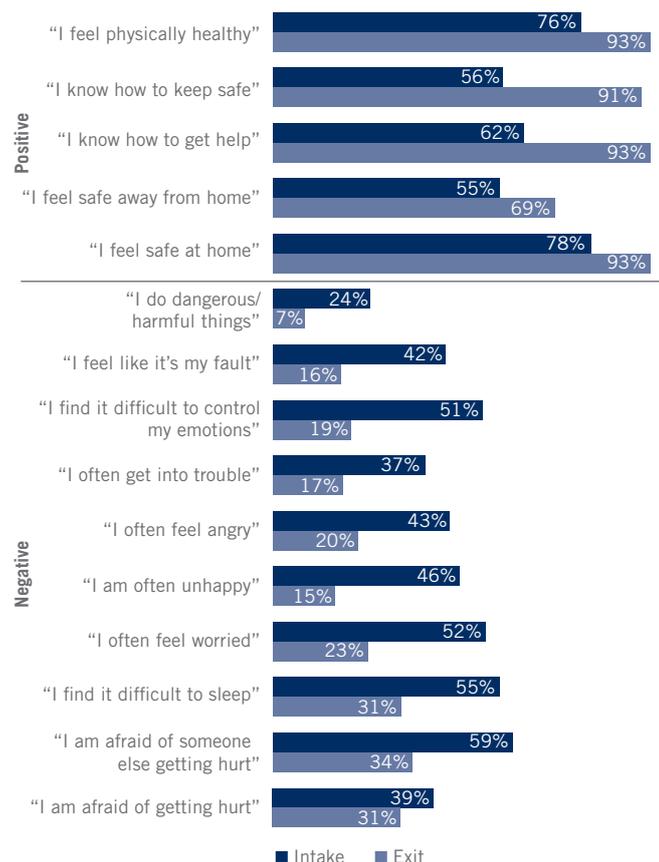
Figure 6: Negative impacts on children's health and wellbeing at intake and exit, as measured by children's caseworkers

These data represent a special matched sample where intake and exit were present; therefore do not match the data appendix.



## Figure 7: Health and wellbeing indicators at intake and exit, as reported directly by children

These data represent a special matched sample where intake and exit were present; therefore do not match the data appendix.



### Box 1: The child's voice

"Every time I felt scared I wanted to go into my room, curl up into a ball and start screaming." Chloe\*

"I don't feel safe at school 'cos my dad says he's going to come and take me away. I just try and stay with friends, near teachers and near buildings where teachers are." Peter\*

"There was physical violence twice a week [during contact sessions] in front of him, it was not pleasant for him and not pleasant for me.... my son was in tears.... He was seeing the case worker then and she was vital for him." Daniel's Mum\*

"If my dad would be angry and everything, I would copy him, that's how I got angry... he used to shout at me all the time and I thought that was a good thing." Hassan\*

\* To protect identities, names have been changed.

1.8 In terms of safety, at intake only half (53%) of the children were assessed by the caseworker to be safe from physical harm, a third (37%) safe from psychological harm, and only a quarter able to get help (26%) and keep safe (23%). See figure 5. The children's own assessments bore out the caseworkers' analyses that many were unsafe at home (in matched About You intake and exit forms). Over a third (39%) said they were afraid of getting hurt when adults they lived with argued or disagreed, and almost two-thirds (59%) that they were afraid about someone else getting hurt in the same situation. See figure 7.

1.9 In terms of health and wellbeing (for a sample with matching intake and exit forms), at intake half (52%) had behavioural problems, 60% felt to blame or responsible for negative events, half (52%) had problems with social development and relationships and 39% with school adjustment. See figure 6. Again, the children's own assessments bore out, and indeed amplified, the caseworkers' concerns about the psycho-social and health impacts. Between a quarter and three-quarters of the children completing forms reported problems with a range of day-to-day activities and emotions at intake, as shown in figure 7.

1.10 These figures, whilst high, still do not adequately express the impact on children of living daily with these experiences and emotions. Box 1 contains anonymised quotes directly from the children and parents in this dataset, for illustration.

1.11 A higher than average percentage of children in the dataset had a Statement of Special Educational Needs (SEN): 4% compared to a national average of 2.8%.<sup>27</sup> This merits further investigation and suggests that there may be a link between exposure to domestic abuse and additional special educational needs; or alternatively that behavioural, emotional or psycho-social effects of domestic abuse may be being misdiagnosed as SEN.

### Two-thirds (62%) of children exposed to domestic abuse were also themselves directly harmed

1.12 We measured whether children were directly harmed in the home as a separate set of measures to whether they were exposed to domestic abuse, in order to assess the overlap of domestic abuse and direct abuse of children. In this report we distinguish between these types of abuse by talking about 'domestic abuse' and 'direct harm to children'. In addition to exposure to the domestic abuse of a parent, our data show that a startling two-thirds (62%,  $n=525$ ) of these children were also directly harmed. Caseworkers were asked to complete

27. For latest SEN averages, see Department for Education website at: <https://www.gov.uk/government/publications/special-educational-needs-in-england-january-2013> [Accessed February 2014].

this section of the form only where the child is being directly harmed *in addition to being exposed to the domestic abuse of a parent*, not just when they are living in a household with domestic abuse.<sup>28</sup> These data allow us to map in some detail the co-occurrence between domestic abuse and the direct victimisation of children across a substantial number of cases.<sup>29</sup> Categories of direct harm to children used in the intake and exit forms are taken from the statutory guidance '*Working together to safeguard children*', as summarised in Box 2.

- 1.13 Of those children who were directly harmed, the most frequent forms were emotional abuse (95%), physical abuse (45%) or neglect (30%) (see figure 8). Calculated as a percentage of the whole dataset, this means that 58% of children were directly emotionally harmed, 28% physically harmed and 18% neglected (see figure 9). As a percentage of the whole dataset (including those not experiencing direct harm), the types of abuse experienced are consistently higher than the national averages of abuse amongst all children up to age 18, reported by the NSPCC (2010). This may suggest that children witnessing domestic abuse are more at risk of a range of direct harm than the child population as a whole. See figure 9 for comparison with NSPCC national averages for all children.
- 1.14 In terms of the severity of the maltreatment, of those children who had been directly harmed, 84% had suffered high or moderate severity emotional abuse, 40% high or moderate severity physical abuse and 24% high or moderate severity neglect, as shown in figure 8.
- 1.15 The primary perpetrator of direct harm to children in the overall dataset was the child's father (in 66% of cases) or mother's male partner (in 27% of cases). The mother was the perpetrator in 11% of cases, a sibling in 6% and another family member in 3%. Figure 10 shows the perpetrators of direct harm to the child, and gives the perpetrator of the domestic abuse for comparison.<sup>30</sup>

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28. The number in this sample is slightly different to the number who were directly harmed overall in the data appendix. Due to the way practitioners were instructed to fill out the forms (as outlined in the main text), all of those identified as being directly harmed should have also been exposed to domestic abuse. However, in a very small number of cases (n = 10), the direct harm section was completed but the exposure to abuse section was not. Therefore, where we refer to those exposed to domestic abuse and who were directly harmed the sample size is slightly lower (n = 525) than for the sample referenced with respect to direct harm alone (n= 535). It is the latter that is referenced in the accompanying data appendix and in the majority of this report in order to show the full picture of direct harm in our dataset.

29. In using Children's Insights caseworkers are trained to define a child as directly abused or maltreated (as opposed to witnessing the abuse of a parent) only when they themselves have been the direct victim. They are instructed not to include children who are or have been living in an abusive household but have not been directly abused, maltreated or neglected.

30. Percentages can total more than 100 because individual cases can involve more than one perpetrator.

## Box 2: Definitions of types of direct harm from Children's Insights

**Physical abuse** may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

**Sexual abuse** involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

**Emotional abuse** is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

**Neglect** is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
  - protect a child from physical and emotional harm or danger;
  - ensure adequate supervision (including the use of inadequate care-givers); or
  - ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.



Figure 8: Direct harm to children (% of those directly harmed)

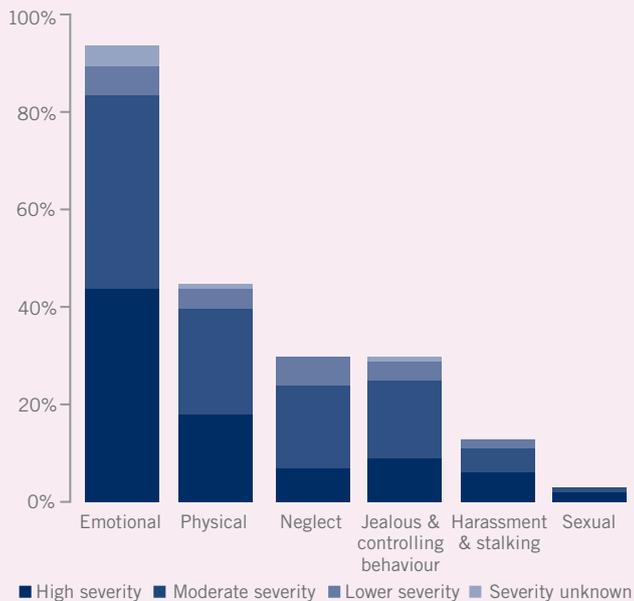


Figure 9: Direct harm to children as a % of whole Children's Insights dataset, with NSPCC whole population averages (where available) for comparison

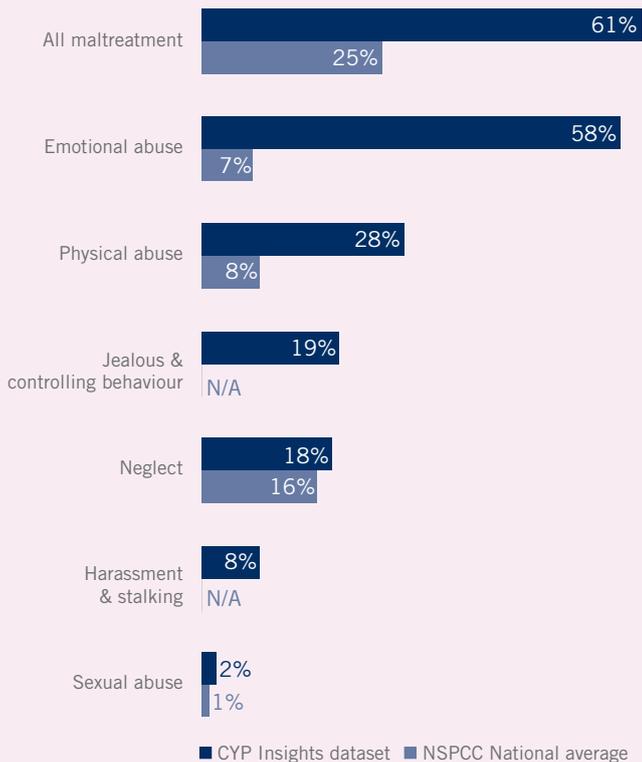


Figure 10: Perpetrators of direct harm and domestic abuse (% of overall dataset)

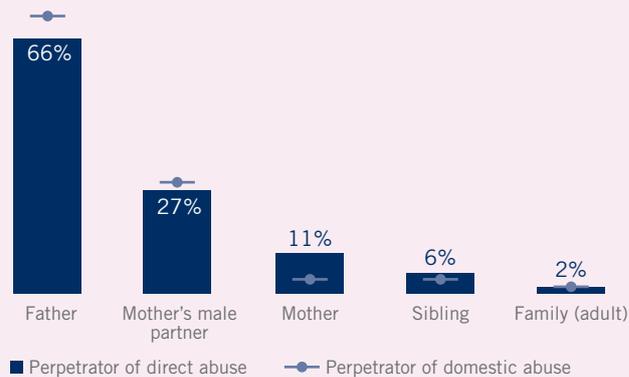


Figure 11: Recipients of child's abusive behaviour

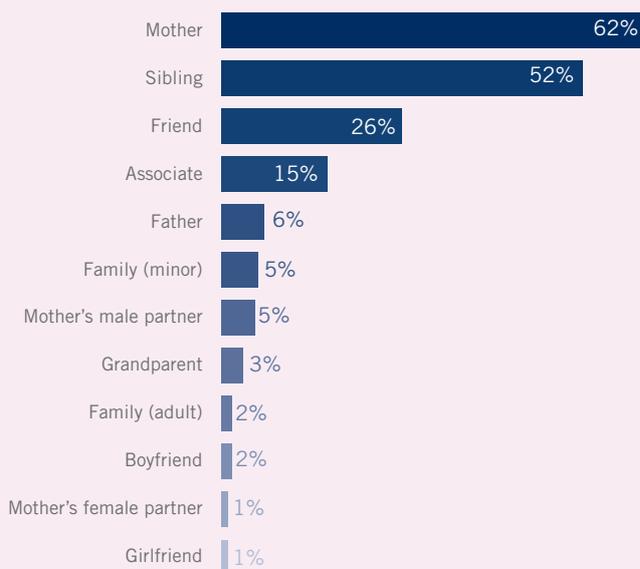
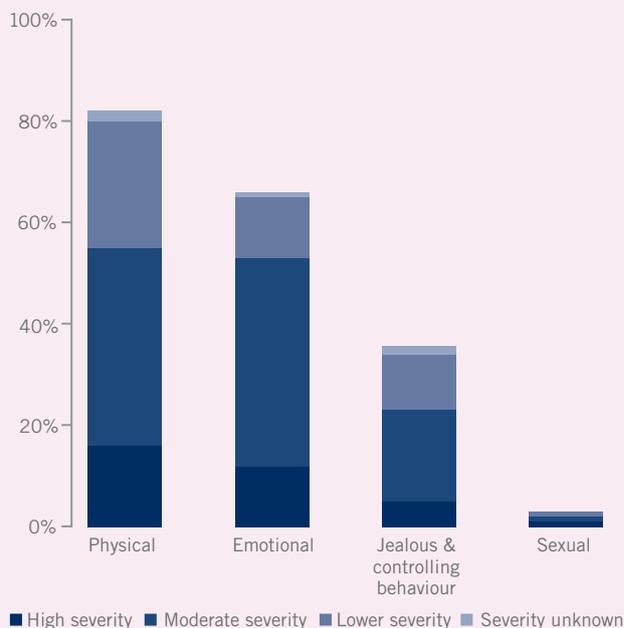


Figure 12: Children's abusive behaviour (% of those showing abusive behaviour)



**1.16** As figure 10 shows, in the majority of these cases the perpetrator of the domestic abuse was also the father or mother's male partner. The inference is that in many cases the perpetrator of both types of abuse is the same. We tested this relationship and found that in 91% of cases where there was both domestic abuse and direct harm perpetrated against the child ( $n=525$ ), a perpetrator was the same. In these cases with a matching perpetrator, the father was a perpetrator in 64% of cases, the mother's male partner in 25%, the mother in 4%, and the sibling in 5%.<sup>31</sup>

**1.17** The data clearly show a pattern of heightened risk for children living with domestic abuse, both risk of harm from exposure to the domestic abuse of a parent, but also an increased risk of direct harm to the child. This suggests that professionals working with families where there is domestic abuse need to be aware that there is likely to be an increased risk to the children of direct maltreatment as well as the risks from exposure to domestic abuse of a parent, and that in domestic abuse cases there is a higher likelihood that the perpetrator of domestic abuse will be the perpetrator of the direct harm to children.

## 25% of children exhibited abusive behaviours

**1.18** A quarter of the children in our research had started to display aggressive or abusive behaviour. Of the 877 cases at intake, 25% were demonstrating abusive behaviour towards others. The most frequent victim of the abusive behaviour (62%) was the mother, followed by a sibling (52%) or friend (26%). Only 6% were abusive towards the father and 5% towards the mother's male partner. See figure 11.<sup>32</sup>

**1.19** The types of abusive behaviour the children displayed were predominantly physical (present in 82% of cases), emotional (66%) and jealous and controlling behaviours (36%). Figure 12 gives the breakdown of abusive behaviours and severity. Physical abuse was most frequent and slightly higher severity.

**1.20** We analysed the data to identify factors which might influence whether children developed abusive behaviour, by comparing those who showing abusive behaviour (group 1) with those who weren't (group 2). Comparing these two groups using cross-tabs identified three key differences:

- Those displaying abusive behaviour had experienced more severe direct harm across a range of categories including neglect, physical abuse and emotional abuse (see table 1);
- At intake, those displaying abusive behaviour were slightly less likely to be currently experiencing direct harm, and more likely to have experienced direct harm in their past (see table 2);
- At intake, those displaying abusive behaviour were less likely to be currently exposed to domestic abuse, and more likely to have been exposed to it in their past (see table 2).<sup>33</sup>

**1.21** The severity of the domestic abuse both groups were exposed to was similar (87% severe or moderate for group 1 and 84% for group 2); the victim and perpetrator were also similar, with the most common victim of the domestic abuse being mother (95% in both groups) and the most frequent perpetrator the father (77% in group 1 and 70% in group 2). There are therefore no obvious alternative explanations within these variables which account for the differences between groups 1 and 2. However, further research might look specifically at this question and explore the possibility using formal statistical modelling.

**1.22** Taken together, these findings suggest that children are more likely to be abusive if they have experienced more severe direct harm (including neglect, physical abuse and emotional abuse), and when they are no longer exposed to domestic abuse and/or direct harm. If there is such a link, we would expect to see higher rates of current abusive behaviour and lower rates of previous abusive behaviour amongst the children who are no longer exposed to abuse. To explore this relationship, cases were divided into children who (at intake) were currently exposed to domestic abuse (group 3) and those who were historically exposed (group 4). The findings bore out the inferred link: the children who were no longer exposed were exhibiting more abusive behaviours (see table 3).

**1.23** We also looked at whether any particular age group were abusive. Table 4 shows that the highest rates of abusive behaviours were amongst 15–17 year old children (42% of that age group). The lowest rates were amongst the under 3s (6%). Between 3 and 15 years old, the proportion of children showing abusive behaviours ranged between 17% and 32%. Over 17 years old, the numbers in our sample are small.

31. We might expect to see a higher representation of fathers or mother's male partners as perpetrators of the harm to children in this dataset than in the population as a whole. This is because a common route into the services in our dataset is from adult domestic abuse services, usually working with mothers who are victims. However, it is worth noting that only 40% of the referrals into these children's services were from a linked adult service; 23% were from other children's services, 14% education and 8% friends and family. So referral routes alone do not explain the very high proportion of perpetrators who are fathers or mother's male partner.

32. A single case can involve multiple types of abuse meaning percentages can total more than 100.

33. Children's Insights records at intake whether the child is/was exposed to domestic abuse and whether the abuse was current or historic; and also whether they are/have been the direct victim of abuse or maltreatment – the caseworker then records whether each type of direct harm is current or historic. Caseworkers are trained to indicate abuse as 'current' if it is within the past 3 months before intake and 'historic' if prior to that period.

Table 1: Direct harm to the child, type by severity, Groups 1 and 2 (higher rates in bold)

Type & severity of direct harm experienced by children	% of group 1 (Abusive)	% of group 2 (Non-abusive)
Physical abuse of child		
Severe or moderate	<b>31</b>	22
Emotional abuse of child		
Severe or moderate	<b>65</b>	50
Neglect of child		
Severe or moderate	<b>18</b>	14

Table 2: Rates of current and historic direct harm to the child, and current and historic exposure to domestic abuse, Groups 1 and 2 (higher rates in bold)

	% of group 1 (Abusive)	% of group 2 (Non-abusive)
Current direct harm to child		
Physical abuse	5	<b>7</b>
Emotional abuse	<b>23</b>	22
Neglect	6	<b>8</b>
Historic direct harm to child		
Physical abuse	<b>25</b>	16
Emotional abuse	<b>36</b>	28
Neglect	<b>14</b>	9
Current domestic abuse	21	<b>31</b>
Historic domestic abuse	<b>75</b>	66

**Table 3: Comparison of current and historic rates of abusive behaviour amongst children no longer exposed to domestic abuse (higher rates in bold)**

	% of group 3 (Currently exposed to domestic abuse)	% of group 4 (Historically exposed to domestic abuse)
<b>Total displaying any abusive behaviour</b>	20	<b>28</b>
Displaying physical abuse	15	<b>23</b>
Of those, currently displaying	<b>97</b>	78
Of those, historically displaying	0	<b>12</b>
Displaying emotional abuse	12	<b>19</b>
Of those, currently displaying	<b>89</b>	82
Of those, historically displaying	0	<b>9</b>
Displaying jealous & controlling behaviours	5	<b>10</b>
Of those, currently displaying	<b>85</b>	81
Of those, historically displaying	0	<b>8</b>

**Table 4: Children showing abusive behaviour by age group**

Age group	Abusive behaviour (% of age group)	No abusive behaviour (%of age group)	Missing (% of age group)
<=3 (52)	5.8	92.3	1.9
<=5(62)	24.2	71	4.8
<=7(145)	17.2	77.9	4.9
<=9(167)	24.6	73.1	2.3
<=11(160)	32.5	63.1	4.4
<=13(134)	26.1	69.4	4.5
<=15(78)	29.5	62.8	7.7
<=17(60)	41.7	53.3	5
<=19(16)	12.5	81.3	6.2
<=21(2)	50	0	50
>21(1)	0	0	100

# KEY FINDINGS

## Identifying children

### Only half (54%) previously known to statutory children's social care

**2.1** Analysis of Serious Case Reviews has shown that domestic abuse is present in two-thirds of death or serious harm of children.<sup>34</sup> However, despite the known links between domestic abuse and child maltreatment, our data show that agencies with the statutory lead duty to protect children from harm are still not always identifying children exposed to domestic abuse. Of the 849 children exposed to domestic abuse, only half (54%) were previously known to children's social care when they engaged with the specialist children's service ('at intake'). This was two thirds (63%) for those children exposed to severe domestic abuse. Some 41% were recorded as not known to children's social care at intake, and a further 5% didn't know or were missing data. Considering only the group of children who had been directly harmed, a third (34%) were not previously known to children's social care at intake.<sup>35</sup>

**2.2** The indications are that those cases known to children's social care at intake tended to be those where the direct harm to the child was severe. As figure 13 shows, when divided down by type of harm to the child, a marginally higher percentage of cases were known to children's social care where the direct harm to the child across different abuse types was high severity. However, between 8% and 26% of cases involving severe direct harm were still not known to children's social care; this rose to between 25% and 35% for children living with direct harm across all severity levels (see figure 13).

Figure 13: Percentage of cases previously known to children's social care at intake to the specialist children's service, by type and severity of direct harm to the child

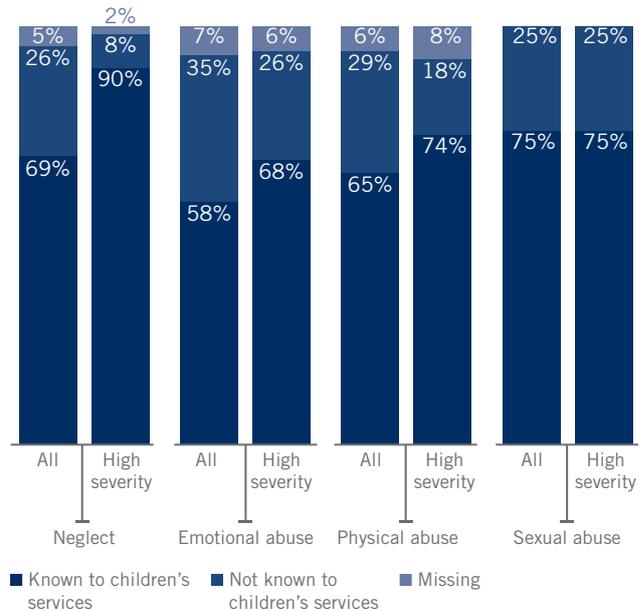
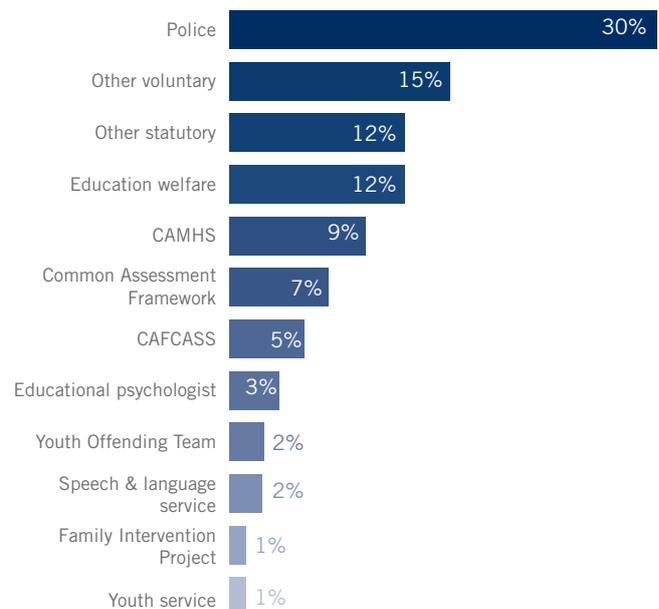


Figure 14: Other agencies involved with the family at intake (see data appendix for abbreviation definitions)



34. Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2011), 'New learning from serious case reviews: A two year report for 2009-11'. London: Department for Education.

35. The measure 'previously known to children's social care' includes both cases with current involvement from children's social care at intake, and those with previous involvement. At intake, caseworkers first checked with the referring agency whether the family had previously been or were currently involved with the family; if this information was not available they asked the family directly.

**Table 5: Cases previously known to Children’s social care (current or historic) prior to intake to specialist children’s service, by age group**

Age group	Known to children’s social care (% of all in age group)	Not known to children’s social care (% of all in age group)	Missing (% of all in age group)
<=3 (52)	75	21.2	3.8
<=5(62)	64.5	29	6.5
<=7(145)	56.6	37.2	6.2
<=9(167)	52.1	42.5	5.4
<=11(160)	51.3	44.4	4.3
<=13(134)	55.2	38.8	6
<=15(78)	44.9	50	5.1
<=17(60)	43.3	55	1.7
<=19(16)	37.5	50	12.5
<=21(2)	50	50	0
>21(1)	0	100	0

**2.3** It seems also that children’s social care were more likely to be involved in cases with younger children: 75% of those cases with under 3s and 65% of those with 3 to 5 year olds in the dataset were known to them prior to intake. By contrast, their involvement was lowest with older children: only 45% of cases with 13 to 15 year olds and 43% of those with 15 to 17 year olds (see table 5).

### But 80% of families were known to at least one agency

**2.4** In our overall dataset, other agencies were involved with these families prior to their intake to the children’s services in 60% of cases, most commonly the police (30% of cases). See figure 14 for the full range of agencies.

**2.5** We looked in more detail at those cases which were not known to children’s social care prior to intake to see how

many were known to another public agency. Of the 41% ( $n=359$ ) of cases not previously known to children’s social care, 48% ( $n=173$ ) were known to at least one other agency and 52% ( $n=186$ ) were not known to any other agency. As a proportion of the overall dataset, this means that 20% of these children were not previously known either to children’s social care or to any other agency. So 80% of these children were in plain sight of a public agency.

**2.6** These data raise questions about the capability of children’s safeguarding services and other statutory agencies consistently to identify and respond to children living with domestic abuse. This is particularly significant given the recognised risk factor of domestic abuse in child protection cases, and our evidence that two-thirds of these children were also being directly harmed.

# KEY FINDINGS

## Providing effective help

### The relationship between domestic abuse and direct harm to children

- 3.1** To explore further the relationship between children's exposure to domestic abuse and their experience of direct harm, a comparison was run between the children who, at intake, were currently exposed to parental domestic abuse ('group 5') and those who had been historically exposed ('group 6'). As shown in table 6, a relationship was found between the ending of the parental domestic abuse and the cessation of the direct harm perpetrated against the child.<sup>36</sup>
- 3.2** There were no obvious differences in the profile of the domestic abuse between the two groups which would explain this relationship, in terms of severity of the domestic abuse,<sup>37</sup> the victim of that abuse<sup>38</sup> or the perpetrator.<sup>39</sup> The child's experience of domestic abuse was also very similar in terms of the proportion who were at home when abuse took place,<sup>40</sup> the proportion injured as a result of abuse,<sup>41</sup> and children's feelings of responsibility.<sup>42</sup> Again, a future study might consider formally testing these findings using statistical modelling.

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36. We considered the possibility of measurement bias, for instance that the existence of current domestic abuse between the parents is assumed by practitioners intrinsically to involve the direct abuse of the child and therefore the direct abuse of the child is automatically assumed to fall when the domestic abuse stops. However, whilst the guidance for completing the Children's Insights data includes 'witnessing the abuse of another' as one aspect in the definition of emotional abuse, witnessing abuse alone does not count towards the categories of neglect and physical abuse; and these also drop off once domestic abuse is deemed historic. For instance, whilst we could posit that being exposed to the current domestic abuse of a parent automatically also entails the emotional abuse of that child, and therefore expect levels of emotional abuse to drop off steeply once the domestic abuse is historic, the levels of neglect and physical abuse also mirror this, bearing out the theory that direct abuse of the child in addition to the direct abuse of the parent is happening and is higher in the case of current domestic abuse, falling off once the abuse is historic.

37. Similar in both groups: 91% moderate or severe in group 5, 84% in group 6.  
38. Overwhelmingly the mother – 97% in group 5, 96% in group 6.  
39. Overwhelmingly the father (74% in group 5, 73% in group 6) or mother's male partner (24% in group 5, 30% in group 6).  
40. 95% were at home in group 5, 95% in group 6.  
41. 19% were injured in group 5, 17% in group 6.  
42. 40% felt responsible in group 5, 39% in group 6.

**3.3** To test this relationship further we took those cases ( $n=166$ ) where there was both current domestic abuse and current direct harm to the child at intake to the service and looked at what happened by exit from the service ( $n=96$ ), using cross-tabs. We found a statistically significant association (determined by chi-square  $\chi^2(6) = 99.14$ ,  $p < .001$ ) between cessation of exposure to domestic abuse at exit and cessation of direct harm of the child at exit. Although this analysis alone does not test causality, from a practical perspective we infer that ending domestic abuse has a causal effect on reducing or ending direct harm to the child. This is consistent with the fact that the perpetrator of the domestic abuse and the direct harm is the same in most of these cases.

**3.4** This strongly implies that safely ending domestic abuse should be a core focus not only for adult services, but for all agencies concerned with child protection and welfare. It is not solely a matter pertaining to the wellbeing of the parents: ending domestic abuse is crucial for children's safety. However, it should be noted that separation is often a time of heightened risk to mothers and children. Whilst these data suggest that, overall, ending domestic abuse directly improves children's safety from direct harm, there may also be greater immediate risk to the family at or just after separation.

### Support for parents with domestic abuse

**3.5** Latest data from CAADA's adult Insights National Dataset 2012–13 show that 69% of domestic abuse ceased at the point of case closure after support from an IDVA.<sup>43</sup> Analysis of MARAC data also shows that in 45% of cases there is a cessation of police call outs in the 12 months after a MARAC.<sup>44</sup> Yet, in this dataset, only 42% of the children's parents who were victims were receiving support from a specialist domestic abuse service, and 26% were receiving no support at all. This was even lower with the perpetrator of the domestic abuse. Only 6% were supported by a service and 55% received no support at all.<sup>45</sup>

**3.6** Evidence from the Early Intervention Foundation shows that parenting programmes which identify and address domestic abuse can be a critical form of early intervention and help for these families.<sup>46</sup> Yet only 6% of parents in our dataset accessed any form of parenting support.<sup>47</sup>

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43. CAADA (2014), Insights adult National Dataset 2012–13 (forthcoming).

44. CAADA data, unpublished. See CAADA (2012) 'CAADA eNews' (March/April 2012) [online]. Available at [www.caada.org.uk/news/caada-enews-Mar2012-MARAC-outcomes-research.html](http://www.caada.org.uk/news/caada-enews-Mar2012-MARAC-outcomes-research.html) [Accessed January 2014].

45. See Children's Insights Dataset 2012–13 for full data on parents accessing support.

46. Early Intervention Foundation (2014), 'Domestic violence and abuse review'. London: Early Intervention Foundation. pp.71–77. Parenting programmes highlighted in the report include: Family Nursing Partnership, Triple P, and Incredible Years.

47. See Children's Insights Dataset 2012–13 for full data on parents accessing support.

**Table 6: Rates of direct harm to children exposed to domestic abuse currently and historically (higher rates in bold)**

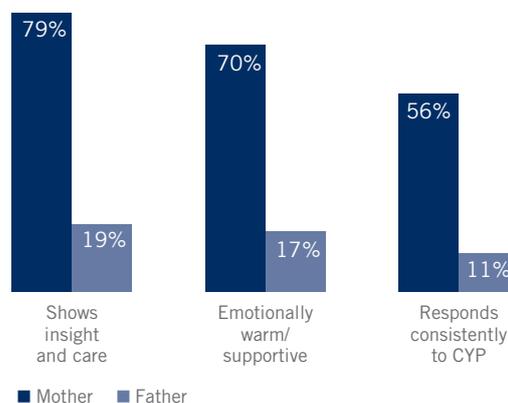
	% of group 5 (Current parental DV)	% of group 6 (Historic parental DV)
<b>Current direct abuse</b>		
Physical abuse	<b>17</b>	2
Emotional abuse	<b>54</b>	9
Neglect	<b>18</b>	4
<b>Historic direct abuse</b>		
Physical abuse	8	<b>23</b>
Emotional abuse	9	<b>40</b>
Neglect	8	<b>12</b>

**3.7** Our data show that despite living with domestic abuse or its aftermath, mothers (and in some cases fathers) are seen to be able to maintain warm and supportive relationships with their children. As shown in figure 15, at intake most mothers (79%) were deemed by the children’s caseworker to show insight and care about the risk to the child, 70% were assessed to have an emotionally warm/supportive relationship with the child and 56% to be able to respond consistently to the child. This was true of fewer fathers, with 19% deemed to show insight and care, 17% were assessed to have an emotionally warm/supportive relationship and 11% to be able to respond consistently.

**3.8** These proportions are broadly borne out by the children’s assessments. Of the 331 children who completed ‘About You’ Intake forms, 78% said that they had a good relationship with their mum. Children were more optimistic about their dads than the caseworkers were, with 42% saying that they had a good relationship with their dad.<sup>48</sup> On the other hand, given that in the majority of cases in this dataset the mother was the victim of domestic abuse and the father or mother’s male partner the perpetrator, we would expect to see a more positive assessment of the mother’s parenting capacity than the father’s in these data. Similarly, children’s optimism and hope about their relationships with their parents may colour their own assessments of both parents’ abilities to respond well. This may suggest that many mothers retain an underlying ability to maintain supportive, warm relationships with the children, as measured both by caseworkers and the children themselves, even if they are not fully able to exercise these capacities or consistently protect their children whilst experiencing domestic abuse.

**3.9** There were a range of residency and child contact arrangements in place when families engaged with the service. Some 91% of the children were living with their mother and 16% with their father (see figure 16). A range of formal and informal contact arrangements with the non-resident parent were in place: 23% of non-resident fathers had informal and 6% formal direct unsupervised access, and 2% had informal and 4% formal direct supervised access (see table 7). In 32% of cases where children were exposed to domestic abuse ( $n = 849$ ) contact was assessed by the children’s caseworker as being used as an opportunity for ongoing abuse (see Children’s Insights Dataset 2011–13).

**Figure 15: Parents’ relationship with child at intake, as assessed by children’s caseworkers**



48. See Children’s Insights Dataset 2011–13 for the full data from ‘About You’ forms.

Table 7: Contact arrangements with non-resident/abusive parent

contact arrangements	n=877						%
	Mother/carer		Father/carer		Abuser, if different		
	Informal	Formal	Informal	Formal	Informal	Formal	
Direct unsupervised	10%	1%	23%	6%	2%	0%	
Direct supervised	1%	1%	2%	4%	0%	1%	
Indirect	1%	0%	4%	1%	1%	0%	
None allowed	0%	0%	5%	7%	2%	3%	
None	1%	0%	12%	8%	5%	4%	

**3.10** Parents were supported in a number of ways by the specialist children’s service. In one third of these families (35%) there was conflict over child contact or residence at intake. At exit one quarter (27%) had accessed support with child contact arrangements. Of these 27%, almost all (97%) had safety issues relating to contact addressed. See Children’s Insights Dataset 2011–13 for the full list of interventions accessed.

**3.11** Only 6% of parents accessed parenting support with the help of the specialist service, including parenting programmes and parent support programme (e.g. Home Start).<sup>49</sup> Recent evidence from the Early Intervention Foundation shows that targeted parenting programmes, such as the Family Nurse Partnership modified with an interpersonal violence element, can be a critical form of early intervention for families experiencing domestic abuse.<sup>50</sup>

**3.12** Yet only 6% of parents of children in our dataset accessed parenting support during the child’s engagement with the specialist service. Such specialist children’s services may be a very good way of identifying and referring families to targeted parenting programmes. Strong referral pathways should be developed between these services, adult domestic abuse services and early intervention parenting programmes.

### Specialist services improve children’s immediate safety and health outcomes

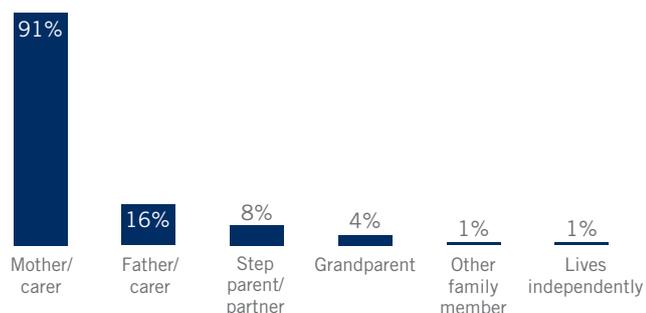
**3.13** Our data show specialist children’s services to be effective in improving immediate safety, health and wellbeing outcomes for children exposed to domestic abuse. Children were supported by the services in a range of different ways (see table 8), including safety planning, dealing with feelings of blame and guilt, and providing access to social and leisure activities.

**3.14** The length of time that children were engaged with the service ranged between a one-off encounter and more than 18 months, with a median case length of 1 to 3 months. Similarly, the number of contacts children had with specialist caseworkers varied between 1 and more than 20, with median number of contacts between 6 and 10. See tables 9 and 10.

**3.15** Across the board children saw substantial immediate improvements in safety, behavioural, emotional, health and wellbeing outcomes at exit when compared to intake. Outcomes across the full range of indicators improved: negative consequences dropped by half to two-thirds across the board, and positive outcomes increased by the same proportions across both caseworker’s assessments and the children’s direct reports. See figures 5 to 7 for comparison of outcomes between intake and exit. Figure 7 shows the percentage improvements in the outcomes reported directly by children. Box 3 contains direct quotes from children and their parents about the value of the specialist services to them. Other indicators can be found in the Children’s Insights Dataset 2011–13.

### Figure 16: Residency arrangements (top 6 categories)

See Children’s Insights Dataset 2011–13 for full list.



49. See Children’s Insights Dataset 2011–13. Some parents accessed both parenting programmes and parent support programmes. This means that the percentages in the data appendix total 7% rather than 6%.

50. Early Intervention Foundation (2014), ‘Domestic violence and abuse review’. London: Early Intervention Foundation.

Table 8: Sample of interventions/support children received. See Children's Insights Dataset 2011–13 for full list

	% of children accessing intervention
Formal safety plan put in place	75
Network of supportive adults informed about their situation	60
Support with understanding the abusive behaviour	51
Support with self-esteem	59
Support with feelings of blame	46
Support with feelings of responsibility for (not) stopping abuse	44
Access to social and leisure activities	26

Table 9: Case lengths for engagement with specialist children's services

Case length	% of cases
One-off	4
Up to 1 month	13
1–3 months	30
3–6 months	29
6–9 months	12
9 months–1 year	4
1 year–18 months	2
>18 months	1

Table 10: Number of contacts with specialist children's caseworker

Number of contacts	% of cases
1–5	29
6–10	39
11–15	10
16–20	5
>20	11

**3.16** These services only tend to work with children for a relatively brief period of time. Whilst they significantly improve outcomes in this time, many of these children may need longer term therapeutic support to recover. At intake, only 9% of children were receiving support from Child and Adolescent Mental Health Services (CAMHS) (see figure 14). By exit from the service, a further 2% had been supported to engage with CAMHS. This seems low, given what these children are living with and the impacts we see in these data.

**3.17** Our data show the immediate positive difference that specialist children's services have across a range of key measures of children's safety, health and wellbeing. Given the well-documented co-occurrence of domestic abuse and child protection concerns, these findings show how vital it is to provide access to specialist children's services and to ensure effective referral routes between them, every adult domestic abuse services and children's social care.

### Box 3: The value of specialist services

"It kind of made me feel like I had someone else to talk to, not just family" Jacob\*

"I like it in the playroom, I feel great and happy" Naomi\*

"My worker helped me to have strategies to help me deal with the emotions raised by my husband and grown up children. Having the support has made a dramatic experience a lot more bearable." Sally\*

"Knowing the effects on my kids has helped me to have boundaries and fight for boundaries for me and them while having contact with their dad" Natalie\*

"The support helped my daughter to be a child again" Rachel\*

"My son had gone through so much when he came into the refuge. He was distant and did not want to play. Now he is a happy chappy. The service has helped him to believe in himself" Sarah\*

"My whole life has completely changed for the better. My children and I are now safe and able to live our lives. Before we were all trapped and very much controlled and at the risk of harm constantly. Now my children feel safe and their confidence is growing very much. They are now able to interact as they should be able to socially and are succeeding at school." Helen\*

"My confidence in managing the situation and reducing the risk to me and the children has increased tenfold. Of course at times it waivers but I always feel much stronger and more able to keep it in perspective after I have spoken to my SAFE worker." Sophie\*

"My reduction in anxiety clearly has a positive impact on the children, my increased confidence in dealing with the situation instils security in them as they can see me stronger and calmer." Jane\*

\* To protect identities, names have been changed.

### These services are effective early intervention for children's abusive behaviour

**3.18** The specialist services in our dataset also achieved good outcomes in reducing the aggressive or abusive behaviour displayed by children. Children were directly supported concerning management of emotions (59%), constructive styles of conflict resolution (45%), understanding of healthy relationships (47%) and coping strategies (59%). Whilst at intake 25% of the children displayed abusive behaviour, by exit the proportion had dropped to 7%.

**3.19** The reduction in abusive behaviour is significant for effective early intervention. Longitudinal and prospective research on offenders and sex offenders has shown that domestic violence is a factor strongly associated with the group of young people who begin offending at an early age and who continue offending as adults (e.g. Moffitt (1993);<sup>51</sup> Moffitt, Caspi, Harrington and Milne (2002);<sup>52</sup> Burton, Duty and Leibowitz (2011)).<sup>53</sup> If, as these data suggest, specialist services are effective at reducing early abusive/aggressive behaviour amongst a group of children at risk, then they also represent a valuable and cost-efficient form of early intervention with young people starting to display anti-social and potentially future offending behaviour.

### CAADA would like to thank the following services for submitting their data:

Domestic Violence and Abuse Service (DV&AS) (Devon)  
Stop Abuse For Everyone (SAFE) (Devon)  
North Devon Against Domestic Abuse (NDADA) (Devon)  
Empowerment domestic abuse service (Blackpool)

### About this report

This research report should be read alongside the recommendations in our policy report, 'In plain sight: effective help for children exposed to domestic abuse' and the full Children's Insights Dataset 2011–13, all available from [www.caada.org.uk](http://www.caada.org.uk)

51. Moffitt, T.E. (1993), 'Adolescence-Limited and life-course-persistent antisocial behavior: A developmental taxonomy'. *Psychological Review*, 100(4), pp. 674–701.
52. Moffitt, T.E., Caspi, A., Harrington, H., and Milne, B.J. (2002), 'Males on the life-course-persistent and adolescence-limited antisocial pathways: Follow-up at age 26 years'. *Development and Psychopathology*, 14, pp.179–207.
53. Burton, D.L., Duty, K.J. and Leibowitz, G. S. (2011), 'Differences between sexually victimized and nonsexually victimized male adolescent sexual abusers: Developmental antecedents and behavioral comparisons'. *Journal of Child Sexual Abuse*, 20(1), pp.77-93. DOI:10.1080/10538712.2011.541010.

# About CAADA

Co-ordinated Action Against Domestic Abuse (CAADA) is a national charity supporting a strong multi-agency response to domestic abuse. Our work focuses on saving lives and saving public money. CAADA provides practical help to support professionals and organisations working with domestic abuse victims.

CAADA Insights is an outcomes measurement service designed specifically for the domestic abuse sector. It evidences the outcomes that domestic abuse services have on victim safety, enabling services and commissioners to make a stronger case for funding and service improvement.

CAADA Children's Insights is a tried and tested tool for frontline domestic abuse services which profiles and evidences outcomes for children. It will shortly be launched to services and commissioners across the UK.



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