Therapeutic interventions for victims of intimate partner violence

EVIDENCE BRIEF

Therapeutic interventions (such as counselling) aim to reduce the long-term effects of intimate partner violence (IPV) on victims. This evidence brief focuses on the effect of these interventions on reducing victims' vulnerability to IPV revictimisation, with some international research showing they can help to reduce it. More controlled studies are needed to build the evidence base.

OVERVIEW

- In this brief, the term 'therapeutic interventions' refers to therapies (e.g. counselling, psychotherapy, cognitive-behavioural programmes) designed to assist IPV victims to manage its psychological effects (e.g. posttraumatic stress, depression, low self-esteem) and help reduce their vulnerability to revictimisation.
- In New Zealand, the Ministry of Justice (MOJ) and Ministry of Social Development (MSD) fund therapeutic interventions for IPV victims. The Accident Compensation Corporation (ACC) funds treatments for mental injuries caused by sexual abuse or a physical injury, some of which arise from IPV.
- Two international meta-analyses found that therapeutic interventions for IPV victims contribute to reducing their vulnerability to revictimisation. One of these meta-analyses showed statistically significant positive effects. This meta-analysis of short-term psychotherapy interventions found that treatment reduces revictimisation by 16%. This means that for every 6 IPV victims who participate in these interventions, 1 will not experience future IPV events.
- In New Zealand, MOJ and MSD have not assessed the effectiveness of their respective programmes to date. ACC is currently assessing the effectiveness of its Integrated Services for Sensitive Claims (ISSC) in relation to mental injuries caused by sexual abuse, so no findings were available for this brief.
- More controlled studies about the effect of therapeutic interventions on IPV victims' vulnerability to revictimisation are needed to build the evidence base.

INVESTMENT CLASS SUMMARY

Evidence rating:	Very promising
Effect size (number needed to treat):	One meta-analysis found no statistically significant effect, while another found that for every 6 treated IPV victims, 1 will not experience IPV revictimisation
Total central government funding:	MOJ: approximately $1.32m (excl GST) in 2015/16 ACC: approximately $20.8m (excl GST) in 2014/15 for treatment for mental injuries caused by sexual abuse or a physical injury, some of which arise from IPV MSD: No information is available at the time of writing
Unmet demand:	Low for IPV victims who receive government funded therapeutic interventions, but the true level of demand cannot be established due to the hidden nature of IPV; in 2013, 24% of violent interpersonal offences by an intimate partner were reported to Police[i]

New Zealand Police Nga Pirihimana O Aotearoa
Ministry of Justice Tāhū o te Ture
Department of Corrections Ara Poutama Aotearoa

WHAT DOES THIS BRIEF COVER?

This evidence brief covers international and New Zealand research on whether therapeutic interventions for IPV victims, help reduce their vulnerability to IPV revictimisation.

Given that cognitive and behavioural factors (e.g. depression, substance abuse) are associated with increased likelihood of IPV victimisation,[ii] then treating such factors effectively should reduce victims' risk of revictimisation. For example, a victim's heavy drinking might impair their ability to use strategies that keep them safe from IPV, such as leaving their home quickly, so helping them address their drinking problem is likely to decrease their risk of revictimisation.

Therapeutic interventions for IPV victims aim to treat psychological harm and help victims develop and use positive coping mechanisms. An international meta-analysis and systematic reviews of therapeutic interventions for IPV victims concluded there is evidence these interventions have a positive effect on victims' mental health (e.g. depression, anxiety) and behaviour (e.g. alcohol use).[iii]

McWhirter[iv] reports that untreated trauma experienced by IPV victims can increase their vulnerability to revictimisation. In addition, IPV revictimisation is a frequently studied effect of IPV programmes.[v] It is important to note however, that having IPV risk factors does not necessarily mean a victim will be revictimised.[vi]

This brief does not report on: IPV identification techniques (e.g. screening); prevention initiatives (e.g. education in schools); crisis responses (e.g. immediate crisis counselling, refuge services); victim home safety services (e.g. home security); legal responses (e.g. protection orders); peer support groups; child abuse treatments; or programmes for IPV perpetrators.[1]

If an IPV victim has children, then these children could see, hear and/or try to intervene in this violence. This type of exposure constitutes emotional or psychological harm for children.[vii] There is a separate evidence brief on therapeutic interventions for children exposed to IPV.

[1] There is a separate evidence brief on treatment for family violence perpetrators.

DELIVERY OF THERAPEUTIC INTERVENTIONS FOR IPV VICTIMS IN NEW ZEALAND

MOJ

MOJ funds safety programmes for people aged 17 and over, who are covered by a protection order under the Domestic Violence Act 1995. These programmes are based on international research and best practice.

The safety programmes have three components:

- needs identification – initial assessment of the victim's immediate risk of IPV
- safety planning – comprehensive assessment of the victim's risk of IPV, developing safety strategies and linking with other services (e.g. housing support services)
- supporting safety sessions – exploring the effects of IPV, assisting victims to heal from the effects of this violence and developing strategies they can use to keep themselves safe from any future violence.

ACC

As part of its ISSC service, ACC funds assessment and treatment services for people who have suffered a mental injury[2] that is a result of sexual abuse, which might have been carried out by an intimate partner. Under the ISSC, an individual can access up to 14 hours of support and treatment, up to 20 hours of family/whanau support and up to 10 hours of social work support without the requirement that their mental injury is covered by ACC.

ACC also funds psychological services for people who have suffered a physical injury from IPV that is covered by ACC, where the effects of the physical injury are a significant factor which has led to a mental injury or psychological problems that are preventing them from recovering from the physical injury. The number of treatment sessions depends on the client's needs.

ACC can provide clinical psychiatric services for some mental injuries caused by sexual abuse or physical injury, for example anxiety disorders, conduct problems and trauma-related disorders. The number of treatment sessions provided to each person depends on their individual circumstances.

MSD

MSD funds counselling for IPV victims as part of its family violence intervention services.[viii] No other information about the counselling is available at the time of writing.

[2] A mental injury is defined in section 27 of the Accident Compensation Act 2001 as a "…clinically significant behavioural, cognitive, or psychological dysfunction." Accessed on 20 September 2016 from http://www.acc.co.nz/making-a-claim/what-support-can-i-get/ECI0023.

DO THERAPEUTIC INTERVENTIONS REDUCE VULNERABILITY TO REVICTIMISATION?

International evidence

The international research on whether therapeutic interventions reduce IPV victims' vulnerability to revictimisation typically comes from the United States.

One meta-analysis (covering 18 studies with and without control groups) found that short-term psychotherapy interventions led to a statistically significant reduction in future IPV events for victims.[ix] The results show that 6 victims need to take part to prevent 1 from revictimisation.

Another meta-analysis (covering 11 studies with control groups) found that IPV mental health programmes did reduce the recurrence of IPV for programme participants, although this effect was not statistically significant.[x]

Two studies about the effectiveness of cognitive-behavioural therapy for IPV victims found that participants who completed the treatment successfully were less likely to report re-abuse at the 6-month follow-up.[xi]

One randomised controlled trial found that cognitive-behavioural counselling reduces IPV revictimisation compared with a single information session.[xii] At 3 months' follow-up, women in the counselling group were statistically significantly more likely than women in the information session to report decreases in: minor physical or sexual IPV (17% reduction in revictimisation, assuming 20% untreated recidivism); minor psychological IPV (15%); and severe psychological IPV (16%).

The Moms' Empowerment Program (MEP) in the United States uses mental health and advocacy services to support mothers exposed to IPV. Miller et al.[xiii] found that mothers who participated in MEP reported less IPV victimisation at the 6- to 8-month follow-up than non-participants.

McFarlane et al.[xiv] studied the effectiveness of three interventions designed to decrease future IPV events for pregnant women receiving routine prenatal care, in public health clinics, in the United States. The women were randomly assigned to three intervention groups: giving women information about agencies that assist IPV victims; unlimited access to counselling; unlimited access to counselling and mentoring. At 18 months' follow-up, there was a statistically significant reduction in the severity of IPV revictimisation across all intervention groups; there were no statistically significant differences between these groups.

New Zealand evidence

MOJ and MSD have not assessed the effectiveness of their respective services to date.

ACC introduced their ISSC service in November 2014. They are using Deakin University's Personal Wellbeing Index and the World Health Organisation's Disability Assessment Schedule 2.0 to capture client outcomes from this service. ACC is currently analysing these data so no findings were available for this brief.

WHAT MAKES THERAPEUTIC INTERVENTIONS EFFECTIVE?

As noted on page 2, given that untreated trauma experienced by IPV victims can increase their vulnerability to IPV revictimisation,[v] and that the cognitive and behavioural factors which therapeutic interventions aim to treat are associated with increased likelihood of revictimisation,[iii] then treating these factors effectively should reduce victims' risk of revictimisation.

Arroyo et al.[xv] found that the factors which make therapeutic interventions more effective are:

- providing individual therapy rather than a group programme
- tailoring an intervention to the needs of IPV victims
- the total amount of time spent in therapy, with more time associated with better outcomes. The researchers did not comment on whether this effect is independent of the healing effect of the passage of time.

The Ministry of Women's Affairs[xvi] identified ways for ensuring that interventions better meet the needs of IPV victims from ethnic groups other than Pākehā, Māori and Pasifika:

- ensuring that language barriers do not prevent IPV victims from accessing services by, for example, employing bilingual staff, using interpreters and providing information in multiple languages
- developing services that take into account victims' cultural beliefs and practices
- providing same language support groups for victims.

WHAT OTHER BENEFITS DO THERAPEUTIC INTERVENTIONS HAVE?

International research shows that therapeutic interventions have a positive effect on a range of outcomes for IPV victims, including their mental health, behaviour, social connectedness and family relationships.[xvii] One example of the latter comes from Graham-Bermann et al.[xviii] who conducted a randomised controlled trial of MEP and found that mothers who took part in it showed greater improvement in their parenting skills at the 8-month follow-up, than non-participants.

CURRENT INVESTMENT IN NEW ZEALAND

In 2015/16, MOJ spent approximately $1.32m (excl GST) on safety programmes for people aged 17 and over.

In 2014/15, ACC spent the following amounts on treatments for mental injuries or psychological problems caused by sexual abuse, or mental injuries as a result of a physical injury, some of which arise from IPV:

- approximately $5.1m (excl GST) on ISSC
- approximately $6.4m (excl GST) on sexual abuse counselling
- approximately $22,000 (excl GST) on physical injury counselling
- approximately $5.5m (excl GST) on psychological services
- approximately $3.8m (excl GST) on clinical psychiatric services.

No information is available about MSD's investment in counselling services, at the time of writing.

EVIDENCE RATING AND RECOMMENDATIONS

Each Evidence Brief provides an evidence rating between Poor and Very Strong.

According to the standard criteria for all Evidence Briefs,[3] the appropriate evidence rating for therapeutic interventions for IPV victims is Very Promising.

Poor	Robust evidence that investment does not reduce or increases vulnerability to revictimisation
Speculative	Little or conflicting evidence that investment can reduce vulnerability to revictimisation
Fair	Some evidence that investment can reduce vulnerability to revictimisation
Very Promising	Robust international *or* local evidence that investment tends to reduce vulnerability to revictimisation
Strong	Robust international *and* local evidence that investment tends to reduce vulnerability to revictimisation
Very Strong	Very robust international and local evidence that investment tends to reduce vulnerability to revictimisation

According to our standard interpretation, this rating means that:

- there is robust international or local evidence that the investment tends to reduce vulnerability to revictimisation
- the investment may well reduce vulnerability to revictimisation if implemented well

[3] Available at http://www.justice.govt.nz/justice-sector-policy/key-initiatives/investment-approach-to-justice/what-works-to-reduce-crime/

- further evaluation is desirable to confirm the investment is reducing vulnerability to revictimisation and to support the fine-tuning of the investment design.

More controlled studies about the effect of therapeutic interventions on IPV revictimisation are needed to build the evidence base.

It would be beneficial to consider how IPV can be defined, prevented, treated and researched from a Kaupapa Māori perspective, given that Māori are over-represented in family violence statistics both as victims and offenders.[xix]

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FIND OUT MORE

Web

http://www.justice.govt.nz/justice-sector-policy/key-initiatives/investment-approach-to-justice/

Email

investmentapproach@justice.govt.nz

Recommended reading

Arroyo, K., Lundahl, B., Butters, R., Vanderloo, M. & Wood, D. (2015). Short-Term Interventions for Survivors of Intimate Partner Violence: A Systematic Review and Meta-Analysis. *Trauma, Violence & Abuse*, 1-17.

Hackett, S., McWhirter, P. & Lesher, S. (2016). The Therapeutic Efficacy of Domestic Violence Victim Interventions. *Trauma, Violence & Abuse*, 17(2), 123-132.

SUMMARY OF EFFECT SIZES FROM META-ANALYSES

					Assuming 50% untreated revictimisation	
Treatment type	Meta-analysis	Outcome measure	Effect size	Number of estimates meta-analysis based on	Percentage point reduction in revictimisation (to prevent one person from being revictimised)	Number needed to treat (to prevent one person from being revictimised)
IPV mental health programmes	Hackett et al. 2015	Recurrence of IPV	d=0.551 NS	11	0.23	4
Short-term therapeutic interventions	Arroyo et al. 2015	Recurrence of IPV	g=0.35*	18	0.16	6

* Statistically significant at a 95% threshold
d=Cohen's d or variant (standardised mean difference)
g= Hedge's g
NS=Not significant

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