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Child Victims of Domestic Violence: The Strategic Starting Point

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The phenomenon of children directly affected by or exposed to domestic violence is widespread and comprehensive:

* According to several studies and surveys in Israel and around the world, between 10% -20% of children experience or are exposed to domestic violence
* This is a cross-sectoral phenomenon, affecting families across ethnic, religious, socio-economic status, and other characteristics

With the development of the research knowledge on this subject, definitions are being sharpened for the difficult aspects of this phenomenon. As compared to children in the control group there is a significantly higher risk of:

* Impairment of the overall level of functioning in: studies, social conduct, etc.
* Impaired health function: overeating, sleep problems, self-harm
* Impairment of cognitive functions
* Post-traumatic stress disorder (PTSD) and / or other anxiety disorders
* Risk of developing behavioral problems or antisocial disorder, especially in cases of exposure at an early age

In addition, exposure to domestic violence produces expanding ‘ripples of harm' that affect others over time:

* Intergenerational transmission: exposure to domestic violence as children is the strongest predictor of violent behavior among adults
* There is a high rate of victims of violence and sexual assault within intimate relationships of those who were exposed to domestic violence as children
* High risk of widespread functional problems as adults, including: addictions, mental health problems, financial/work difficulties, and more

\* Future without violence: Summary of international research data

Note: Something general about how difficult / common this phenomenon is and how it should be central, both because of its severe impact on many individuals, and because of its longitudinal social consequences

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Despite the extent and severity of the phenomenon throughout the world, most work on this subject is still in the relatively early stages of crystallization.

Attempts to examine and establish a model of action around the world regarding children affected by domestic violence are characterized by challenges and limitations of the ‘first stage of coping', including:

**Terminology**: No simple, clear and accepted definition of domestic violence at the formal or practical level

**Catalogued information**: Notable gaps in the quantity and quality of information on the scope of the phenomenon and its characteristics

**Intervention methods**: A wide range of therapeutic responses, with no single tool that is clear, accepted, and designated for use

**Boundaries**: Difficulty in setting a clear threshold for violence / abuse in terms of intensity, frequency, characteristics, etc.

**Research**: Significant research confirming the implications of the phenomenon, but little innovation in the nature of the detail and responses required

**Legislation**: Dilemmas, complexities and attempts to refine legal definitions that will adapt to changing definitions and needs

"No model in the world has cracked the problem of children exposed [to domestic violence]. There is difficulty in quantifying the phenomenon'. There is a lot of research but little innovation and only a few adequately strong bases of knowledge." (Prof. Carmit Katz, Tel Aviv University)

Note: There is a definition from the Istanbul Convention but it is vague and general; There is a variable use of the terms - violence or maltreatment; Today it is usually clear that this includes both direct violence and exposure to violence; often, it is common to talk about emotional abuse and neglect; sometimes it also includes economic and verbal violence; it becomes something excessively broad and difficult to grasp accurately; if terminology is talking about the width of a sheet, the boundaries of the section make it difficult to determine the contours along which to cut- where there is a house where people shout and maybe once give a slap, it may be considered domestic violence;

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Despite the extent and severity of the phenomenon throughout the world, most work on this subject is still in the relatively early stages of crystallization (continued)

Even “in these times” a variety of processes can be seen as part of an attempt to stabilize a model

**United Nations**: Development of a plan addressing violence against children, including children exposed to domestic violence, as part of the implementation of sustainable development goals for 2030

**Canada**: Development of a guide to health and welfare factors for identifying and treating children exposed to domestic violence (2020); amendments to legislation related to domestic violence (2021)

**Australia**: National study to examine the extent of child abuse and its consequences (2019-2023); multi-year national plan for dealing with the domestic violence (expected to be completed in 2022)

**United Kingdom:** New legislation on domestic violence including targeted reference to children exposed to domestic violence (2021); Intention to complete, in the coming year, legislation in the context of community responses to the phenomenon

**New Zealand:** Appointment of a minister (female) to prevent domestic violence (2020)

* Much is still unknown about how various clinical and social care services might improve outcomes for children who are indirectly exposed to IPV…”; A review of Treatment Interventions (MSPI 2018)
* “Funded projects reach children affected by violence, while helping to learn and share ‘what works’ in this emerging field...”; Public Health Agency of Canada (PHAC)

Sources: Landmark Domestic Abuse Bill Receives Royal Assent: UK gov, Canada Department of Justice, changes to family laws, VEGA Project - A Public Health Response to Family Violence Canada, Keeping the Promise: Ending Violence Against Children by 2030 UN, The National Plan to Reduce Violence against Women and their Children 2010–2022 Australia, Australian Child Maltreatment Study to identify the prevalence of child abuse and its health impacts

Note: The field is still being developed, there is still no stabilized and clear global best practice in any major aspect of the phenomenon (detection, information, legislation, knowledge, ...) and certainly not a complete and closed coherent model

The UK Health Research Institute is issuing a 'request' for further in-depth research in the field of children exposed to domestic violence; It is said that there is a solid body of knowledge about their adult victims of domestic violence, but very little research supporting what helps children from these families

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In Israel, the current starting point for responding to violence against children in the family is the result of gradual evolution over the past decades.

**Recent years:** Increasing awareness of and focus on children as victims of domestic violence; appointment of an inter-ministerial committee and designation of standard procedures for the care of children; dedicated training at Dimol, other forums (roundtable on victims of crime, community education projects and learning centers, etc.), precedent set in the trial regarding the murder of Shira Isakov, etc.

**2000s:** Increased focus on gender-based violence; development of responses from women's centers, later also for male victims; expansion of the information bases and research knowledge; the establishment of the Haruv Institute

**1990s:** Establishment of emergency centers and out-of-home responses; establishment of the first centers for the prevention and treatment of domestic violence (including initial development of responses for children)

**1970s-1980s**: Preliminary legislation, establishment of the Council for the Welfare of the Child, the establishment of ELI Child Protection Association; beginning of public awareness (case of the death of abused child Moran Denmias from Tiberias)

In the last 2-3 years, there has been a structured and systemic discussion and engagement on the subject of children affected by domestic violence. This allows for establishment of an initial dedicated response and a solid infrastructure for further development and progress (including the current process).

Note: In the 1990s, Einat Peled imported from the United States an initial model for the care of children affected by domestic violence, there is Fleischman's course; some of the centers begin with group therapy followed by individual treatment; But all this fades and disappears without any systemic standardization, leaving only small islands of centers that continue to engage in it in a ‘semi-independent’ way; Project from the IDF (a project to prevent child abuse;) in collaboration with the Child Welfare Council + academics, professionals and more; Shira Isakov - for the first time an indictment against the murderous father which also includes a section on child abuse as being exposed to violence ... a precedent!

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Along with this positive progress, the overall process of dealing with the issue still suffers from significant gaps.

To examine the current model of action in relation to children affected by domestic violence, we will look at four main topics:

System management:

1. Identification
2. Screening and referral
3. Therapeutic response
4. Long-term monitoring, supervision, and development

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It is estimated that the phenomenon is widespread in the population, but the vast majority of cases remain 'below the surface'.

Number of children affected by domestic violence in Israel according to several indices of the extent of the phenomenon:

About 7% reported a family member who pushed / grabbed another family member more than once \*

About 9.8% reported witnessing domestic violence \*\*

About 200K women are victims of domestic violence \*\*\*

All existing indices indicate a very wide range of the phenomena of children affected by domestic violence, likely reaching between 250K and 500K children and adolescents.

Nevertheless, the vast majority of these children are not identified, diagnosed or recognized by the authorities.

Moreover, the existing indices for the scope of the phenomenon are few, partial and inconsistent. There is currently no real ability to quantify the scope of the phenomenon on the basis of clear definitions and continuous examination of indices over time.

Thus, there are deep gaps in the ability to assess the true extent of the phenomenon, its trends over time and its distribution between various sectors, groups and demographic characteristics within the population, distinction between direct harm and exposure to violence, distinction between 'mild' and 'severe' cases, etc.

\* Survey of the Ministry of Public Works (2017)

\*\* Lev-Wiesel & Izkowitz (2016) research, University of Haifa

\*\*\* WIZO (2020) data indicating approximately 3 million children and adolescents in Israel; 3.1 children per family on average

Note: Groping in the dark, perhaps knowing that we do not know; But even the relevant studies - there are 1-2 from at least 5 years ago ...; we engage in this field and don’t even know how to answer the question of whether this is an upward or downward trend (and why); this is an unreasonable reality ... There is reliance, not at all serious, on macro-data of 500K children, but we do not have adequate knowledge to know how to treat this number at all; How many of these 500K, if we knew them in person, would need significant treatment or another response immediately?

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Section on screening and referral: Difficulty in identifying and referring children to the ‘system' for dedicated responses:

* Approximately 400K children recognized by the welfare system; > 50K reports per year according to the Youth Law; > 34K children discussed by planning, treatment and evaluation committees; > 15K reviews of procedures
* Considerable difficulty in identifying, screening, and documenting child victims of domestic violence. The (problematic) data show a declining volume over the years, with about 7,400 children identified as victims of domestic violence in 2020
* Of those identified as victims of domestic violence, the vast majority are referred to centers and programs that are not dedicated to the issue, due to difficulty in accurate distinction and the multiplicity of programs and responses lacking clear and distinct demarcation boundaries
* Most of the children treated at centers for the prevention and treatment of domestic violence were not referred from within the system, but arrived there as a ‘by-product’ of a number of preconditions (which do not necessarily reflect a rationale or policy outlook)

Note: The burdens, partial familiarity with the issue of domestic violence, the difficult problems in proper documentation and the objective characteristics of concealment, shame, etc. ... There is no question that there is a large gap in correctly identifying children who are in the system; But in terms of screening and referral - children are not perceived as direct clients of these centers; the vast majority go to other places and those that arrive are usually brought because of the mother and are not direct clients ...

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Section on treatment in centers against domestic violence:

Renewed development of responses for children, but still at a low and limited rate

* Centers for the prevention and treatment of domestic violence were first established in the mid-1990s, as a dedicated response to the phenomenon of violence against women
* Subsequently, the therapeutic concept was expanded to include men and children. However, in the 2000s the Ministry ceased to deal with the issue in a methodical manner. Only a small number of the centers were 'islands' caring for children, led by people who were 'crazy about the issue’, without proper regulation or central budgeting.
* Dedicated treatment of children affected by domestic violence was officially introduced and made a significant leap forward only in the last two years, following the decisions of the inter-ministerial committee and the allocation of dedicated standards for treating children: at this stage, 68 standards were allocated (out of a total of about 120 designated standards) allowing for treatment of approximately 990 children in 2020.
* In addition to the designated standards, relevant training was developed at the Central School for the Training of Employees in Welfare Services. A number of additional moves were planned / promoted (reinforcement of the information and assistance line 118, campaigns budgeted with about NIS 4 million, digital tools, research on the subject, and more).
* However, since their establishment and until today, the main activity and focus of the centers for the prevention and treatment of domestic violence has been adults, especially women.

Expansion of the scope of the centers and the treatment of children

Centers overall

Centers that treat children

Children constitute a small minority of those treated in the centers (2019 data)

Women, men, children

\* Data from the Ministry of Welfare (annual summary)

Note: The initial treatment of children was either if they were directly harmed or only exposed to parental violence: Prof. Einat Peled ‘imported’ experience and a model from the United States, began specialized training (Fleischmann's course) and some centers began caring for children, especially in groups.

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Section four: Long-term monitoring, supervision, and development:

Large gaps in the perception and application of information collection and processing

|  |  |
| --- | --- |
| **Lack of appropriate goals / metrics +** | **Lack of accurate measurement** |
| * Aside from a basic definition of ‘those in need’ regarding domestic violence, the system lacks defined and accepted indicators for the system-wide or individual collection of information regarding children affected by domestic violence | * Entering data in the Welfare Ministry’s information system (BI) is sporadic and limited: many transfer Excel spreadsheets separately and / or enter data from folders once a year |
| * There are no accepted definitions for 'end of treatment' or 'therapeutic goals' point (including patients’ feelings) | * Data entry is sometimes seen as a useless activity and is done in an unthinking, automatic manner |
| * There are no definitions of desired long-term therapeutic impacts (milestones) | * No information is collected at the end of treatment |
|  | * There is no built-in follow-up of patients over time |

“The definitions of ‘those in need’ are not useful: the overall language of assessment in Israel is not relevant to children: if we examine all the files of the centers, they all have the same title and the same treatment plan, without any distinctions.”

"The information system is just shocking; they have invested so much in computerization, but the rubrics are very superficial, looking for the least bad option; it takes away the desire to do it seriously, and in the end, one fills it out like an automaton.”

Note: For example - there is no distinction between those exposed to violence and those directly injured; between stages of intervention; nature and duration of treatment; demographic and family characteristics; ages at admission to treatment; connections between the different types of centers where the treatment is given, etc., That is - there is no ability to gather normal information about what exists; and certainly not on the results of the activity

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Characterization of the Strategic Starting Point: Interim Summary

* After years of not systemically addressing the issue of children affected by domestic violence, in the last two years there has been a leap forward in the treatment, scope and quality of the response provided.
* However, like the emerging reality around the world, addressing the issue is still in its infancy
* The vast majority (> 95%) of children affected by domestic violence in Israel are not identified and do not appear on the system's radar screen
* A small minority of children identified as victims of domestic violence but not referred for 'out-of-community' treatment, only a low percentage receive treatment within the designated framework of the centers for prevention and treatment of domestic violence (which are not based on structured prioritization).
* The gaps and ambiguity in the action model raise questions in relation to the impact and expectations of the intervention

200K - 500K children are affected by domestic violence (100%?)

About 8K are recognized in the classification of domestic violence (2020) (~2.3%)

990 were treated at centers for prevention and treatment of domestic violence (~ 0.3%)

What is the scope, degree of impact, and added value of the response given at the individual level and at the overall societal level?

How should the current starting point be viewed? Where is it accurate? Can we move forward from here?

Note: Is it good to give care at centers for prevention of domestic violence to about 1,000 children a year? Is it worth the effort? Does 0.3% make sense? More at the macro level - these are questions that are difficult to answer seriously at this stage; even though every child is a whole world, and it must be said that we met dedicated people who work hard in the field - and intuitively, it is clear that most children benefit from this encounter at some level ...

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Objectives and directions for action: Comprehensive examination

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Given the starting point, what are the correct goals that can be set at this stage?

What we want

Policy objectives

Possible directions:

Reduce vulnerability and recurrence of domestic violence over time by addressing an effective and effective response to the majority of children who are victims of domestic violence in Israel

Operational objectives

Possible directions:

Make adjustments in the action model (centers, capabilities, budgets) to focus on strengthening the scope / quality of the response provided

Orientation objectives

Possible directions:

Produce quality metrics and indices that will significantly strengthen the scope and quality of the image over the broad picture across the overall sections of response

What we can achieve

Extensive degree of disorientation:

1. Reading of the current status: Significant gaps in the information and overall picture impair our ability to identify, examine and maintain control over the effectiveness of the current model
2. Reading of the direction: Difficulty in formulating and setting goals, a clear agenda, or guidelines for decisions and consistent actions

Starting point

Note: A reminder of the discussion we barely started the last time ...; Only this time it's an opening for an organized attempt to answer it ...

For all the reasons we mentioned - it is actually difficult at the moment to answer a very basic question in relation to the current activity: Is it helpful? Is it good? It is also difficult to answer because we have very large gaps in information, in understanding, in knowledge, in the ability to examine it ‘in reality; also because we have no clear goals or metrics by which we can assess the activity and its results; Not in clinical, budgetary aspects, scope of activity, etc.; And so we actually have neither a map nor a compass, and that produces disorientation;

Out of this fog, it seems perhaps appropriate to address the question of where we want to go in a gradual way, both on the timeline but also in terms of the types of goals we can set

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Need for a Fundamental Decision

Pertaining to two dilemmas regarding the ‘location’ of treatment for children affected by domestic violence

Responses outside the Welfare Department

Responses within the Welfare Department

Centers for Treatment of Domestic Violence

Dilemma # 1: Should the treatment of children take place only / mainly in existing centers for treatment of domestic violence?

Dilemma # 2: Should the treatment of children affected by domestic violence take place only / mainly within the welfare system?

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Dilemma # 1:

Location and nature of the centers for the treatment of children affected by domestic violence

* In principle, the current model of action is based on treating children within the existing centers for the treatment of violence. In the last two years, some 68 dedicated standards for child care have been added.
* However, even out of the children identified by the system as victims of domestic violence (a small part of the total number of children actually victimized), most are sent to / arrive at a long series of centers and other responses within the welfare system.
* About 90% of the activities in the current domestic violence treatment centers remain focused on adults. These centers suffer from limitations and gaps that limit their ability and effectiveness in offering a broad response to child victims of domestic violence.
* Given the current situation, there are four main alternatives for treatment centers to assist child victims of domestic violence.

1. Strengthening the focus of existing centers for treatment of domestic violence
2. Strengthening responses across other relevant existing types of centers
3. Development of dedicated regional centers
4. Establishment of unified centers for children and families

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Need for a fundamental decision

Pertaining to two dilemmas regarding the ‘location’ of treatment for children affected by domestic violence

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **1**  **Strengthening the focus of existing centers for treatment of domestic violence** | **2**  **Strengthening responses across other relevant existing types of centers** | **3**  **Development of dedicated regional centers** | **4**  **Establishment of unified centers for children and families** |
| **Key benefits** | Direct continuation of the existing model and previous steps taken  Strengthening the issue of domestic violence as a distinct, important and dedicated field | Tailored to the current situation of wide dispersion between centers  Allows more children to receive a relevant response relatively easily, without major physical relocation or travel | Dedicated professional response focusing on children affected by domestic violence, with a broad critical mass that enables improving capabilities and benefits of greater size | Wide range of benefits:  Addresses the issue of visibility and branding  Critical mass  Multidisciplinary capabilities across ages, screening and referral problems  Overall operational efficiency |
|  |  |  |  |  |
| **Key challenges** | Requires significant improvement in the screening and referral phase  Requires development of specially-tailored centers  Does not address the lack of critical mass across centers in terms of staff, multidisciplinary knowledge, etc. | Largely undermines the perception of domestic violence as a central and designated issue  Questions the ability to provide a satisfactory professional answer in centers with significantly different orientation and  core makeup | Questions the usefulness and cost of separate centers for children and adults  Requires major investment in the construction of new centers  Damages the degree of accessibility  Requires considerable reinforcement of screening and referral capability | Need to refine action model, including demarcation of boundaries between centers and internal specializations  Complex implementation in terms of investment and time needed to manifest |

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Current Model of Operation

Limitations Emphasized, Relative to Other Models

Centers for Prevention of Domestic Violence vs. Parent-Child Centers: Sample Comparison

Availability (less stigma)

Encouraging visibility of children

Adjustments for different age groups

Critical mass (size, budget)

Multidisciplinary capabilities

Defining the work as treatment for children

Appointed per person (not per family)

Focus and knowledge on the subject of domestic violence

There is professional value and importance to specialization and dedicated focus on the subject of domestic violence within the centers, but the current model of action suffers from considerable gaps compared to other treatment centers.

Note: On top of all that - it's hard to know exactly, but probably no fewer children affected by domestic violence (certainly directly) are treated in child-parent centers than in designated centers

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Objectives and directions for action:

Framework of action for the coming years

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Roadmap for strengthening the response to children affected by domestic violence

Progress along two parallel axes in the current planning range

Current planning range

Relevant reference horizon

The strategic starting point

Key Effort # 1: Strengthen and improve responses based on the existing model

Key Effort # 2: Build the required infrastructure and examine optimal models

The Next Step: Considerable expansion of the scope of the response (scaling up) based on an up-to-date model and defined policy objectives

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Following the internal discussions:

Agreement with the Ministry on entering into a joint process for targeted promotion of infrastructure development

Following internal discussions and debates, an agreement was formulated, in principle, on entering into a joint process. The main points are:

1. Formulation and detailed characterization of a new model for the preparation of the centers for the treatment of children affected by domestic violence on the basis of the proposed concept of the 'unified centers for children and families' (Alternative # 4)
2. Development of an infrastructure of relevant information and monitoring and control capabilities
3. Implementation of the detailed model as a pilot in several localities (5-10)
4. Evaluative research of the pilot results of the new model: Refinements as required for the action model
5. Preparation to expand the model nationally (scaling up)

Next Steps:

* Detailed description of the nature of the required process: set boundaries, focus, outputs, schedule, budget, etc.
* Examination of appropriate external factors (such as the Rashi Foundation) to promote the process in cooperation with the Ministry