Royal Commission into Family Violence

WITNESS STATEMENT OF PAT TUOHY, HELEN FRASER AND MIRANDA RITCHIE

I, Dr Pat Tuohy, Chief Advisor, I, Helen Fraser, Manager, and I, Miranda Ritchie, Manager, of Floor 1-3, The Terrace, Wellington in New Zealand, say as follows:

1. We are authorised by the New Zealand Ministry of Health to make this statement on its behalf.

2. We make this statement on the basis of our own knowledge, save where otherwise stated. Where we make statements based on information provided by others, we believe such information to be true.

Current roles

3. Dr Tuohy is currently the Ministry of Health's Chief Advisor for Child and Youth Health. He has held this position since December 1997. His responsibilities include provision of specialist child and youth health advice to the Ministry and other Government agencies, coordination and leadership of child and youth health across District Health Boards and child and youth health professionals and organisations.

4. Ms Fraser is currently employed as a Portfolio Manager for the Ministry of Health and is the Issues Lead for Family Violence for the Ministry. Ms Fraser's portfolio includes management of the Violence Intervention Programme which has been implemented in all District Health Boards across New Zealand. Ms Fraser has held this position for three years.

5. Ms Ritchie is the National Violence Intervention Programme Manager for District Health Boards, a role she has held since 2007.

Background and qualifications

6. Dr Tuohy is a specialist paediatrician with a particular interest in community child health. Dr Tuohy initially qualified in Biochemistry at Victoria University, Wellington, and then went on to medical studies at the Otago Medical School, qualifying MB.ChB in 1979. He undertook postgraduate training in paediatrics in Wellington, Melbourne

and Nottingham. On his return to New Zealand he worked as a General Paediatrician in New Plymouth for three years and joined the Plunket Society in 1991 as its Regional Paediatrician based in Wellington. He was later appointed to the position of National Paediatrician for Plunket, until his move to the Ministry of Health in 1997. Dr Tuohy has worked in a range of clinical and academic posts, has chaired or served on a range of international, Royal Australasian College of Physicians and New Zealand Government committees and working groups, and has, for the last 10 years, supervised a Registrar rotation through the Ministry of Health. For the last seven years he has had the role of the National Immunisation Champion for the 'Improving Coverage' immunisation target. Dr Tuohy's particular interests are in the areas of developmental and behavioural paediatrics, SUDI prevention, immunisation and child protection.

7. Prior to working at the Ministry of Health, Ms Fraser worked for one of New Zealand's leading Maori Women's Refuges. Ms Fraser was also previously employed for six years by Child, Youth and Family as a contract specialist to work with non-government organisations who provided social and care services to families and children taken into State custody. Ms Fraser holds a Bachelor of Laws from Waikato University and has practiced as a lawyer.

8. From 2002 to 2007, Ms Ritchie was the Family Violence Intervention and Child Protection Coordinator at the Hawke's Bay District Health Board. From 2004 to 2007 Ms Ritchie was the National Family Violence Intervention Coordinator. Ms Ritchie has co-authored several papers on the evaluation of the Hawke's Bay District Health Board Family Violence programme.

9. Ms Ritchie is a Registered Nurse with twenty years' clinical experience, ten of which were as an Emergency Nurse both in New Zealand and the United Kingdom.

New Zealand health system and family violence

10. In the early 2000s, several events catalysed the whole of government responses to family violence in New Zealand.

11. One such event was the death of four year old Riri-o-te-Rangi (James) Whakaruru on 4 April 1999, from one or more assaults perpetrated by his mother's partner. The New Zealand Commissioner for Children conducted an investigation into James' death pursuant to powers and functions given in the *Children Young Persons and*

Their Families (CYPF) Act 1989 (NZ). The Commissioner for Children's final report stated that:

> '*The investigation found that poor interagency communication characterised the professional work with James and his family. Agencies worked without reference to each other, and ended their involvement assuming that other parts of the system would protect James. Some workers seemed unaware of the indicators of a child at risk or did not appreciate the role they needed to play to ensure his safety and wellbeing. There was little if any attempt to engage culturally-appropriate services, or to address the situation in the context of his wider whānau, hapu and iwi.*'

12. The report made a number of recommendations for change to the Government, Ministers, health services, and police. In relation to the health sector, the final report noted:

> '*The health sector is a vital component of the child safety net, able both to identify children at risk and to monitor and measure ongoing safety and wellbeing.*
>
> *James was seen forty times by health practitioners, four presentations at the hospital emergency department, two admissions and one outpatient clinic, three face-to-face Plunket* [an infant/child support service] *contacts, and thirty visits to general practitioners at four practices. Collectively the health sector had available a telling picture of James' circumstances.*
>
> *This picture was never put together because of poor communication between practitioners. Information was not passed on or was incomplete. Previous records within the same hospital or practice were not viewed, and where James was not known, the records suggest that social and medical histories were not sought or provided. Some individual practitioners appeared to be unaware of signs of possible risk.*'

13. James Whakaruru's death shocked New Zealanders. The Commissioner for Children's subsequent report was very influential and contributed to the willingness of Government, professions and the wider community to address family violence.

14. In 2002, the New Zealand Government released *Te Rito New Zealand Family Violence Prevention Strategy* (**Te Rito**), which was the Government's official

response to, and framework for implementing a previous plan of action released in September 2001. In Māori thought, the harakeke (flax) plant represents the family. The centre shoot (the rito) is the child. It is surrounded by the awhi rito (the parents) as protection. The outside leaves represent the grandparents and ancestors. Attached to this statement and marked '**MH 1**' is a copy of Te Rito dated February 2002.

15. While the Ministry of Social Development coordinated Te Rito, the strategy involved, and required action by all social service government agencies including health, corrections, justice and education, among others.

16. There is no separate plan for Māori. The fact that Māori are overrepresented as victims is recognised within Te Rito and prioritises Māori-based approaches, early intervention and prevention, and evaluation.

Developing family violence guidelines for the health sector

17. By the time of the release of Te Rito, the Ministry of Health had already begun the implementation of family violence intervention guidelines for health sector providers as part of the Ministry of Health Family Violence Health Intervention Project, which started in 2001.

18. The Ministry of Health employed and worked with prominent experts and academics across the health and family violence services sectors to assist in developing the guidelines. Each guideline is also endorsed by relevant government agencies, family violence services, professional associations and medical societies.

Child and Partner Abuse Guidelines

19. In 2002, the Ministry of Health released the *Family Violence Intervention Guidelines: Child and Partner Abuse* (**Child and Partner Abuse Guidelines**).

20. The Child and Partner Abuse Guidelines present a six-step model for identifying and responding to family violence within health care settings. The six steps are:

- Identify
- Support and Empower
- Assess Risk
- Safety Planning and referral

- Document
- Referral Agencies

21. Importantly, given the high co-occurrence of partner abuse and child abuse, the Child and Partner Abuse Guidelines take a dual risk assessment approach and outline an integrated response to addressing both of these issues. When the Ministry of Health began working on the guidelines, there were no other models around the world that took this dual approach. Child abuse and intimate partner violence were dealt with separately.

22. The Child and Partner Abuse Guidelines recognise the role of the health sector in addressing family violence:

> '*Health care providers are in an ideal position to assist victims of family violence before the abuse reaches crisis point. Health providers come into contact with the majority of the population for routine health care, pregnancy, illness, and injury, or by bringing children to health care services. Victims of abuse seek care from health care providers far more often for a range of health problems than do individuals who have not experienced abuse. Health care providers are therefore well placed to engage in early identification, support and referral of victims of abuse, before it escalates to severe or life-threatening levels.*'

23. The Child and Partner Abuse Guidelines also specifically address family violence for Māori whānau, and for Pacific peoples (the seven main Pacific communities in New Zealand are: Tuvalu, Tokelau, Fiji, Tonga, Niue, the Cook Islands and Samoa).

24. Attached to this statement and marked '**MH 2**' is a copy of the Child and Partner Abuse Guidelines dated November 2002.

25. The Ministry of Health also released a resource for general practices to help identify and respond to partner abuse. Attached to this statement and marked '**MH 3**' is a copy of the *Recognising and Responding to Partner Abuse: A resource for general practices* dated June 2003.

Elder Abuse Guidelines

26. In 2007, the Ministry of Health published guidelines addressing elder abuse and neglect. Attached to this statement and marked '**MH 4**' is a copy of the *Family*

Violence Intervention Guidelines: Elder Abuse and Neglect (**Elder Abuse Guidelines**) dated August 2007.

27. The Elder Abuse Guidelines are similar to the Child and Partner Abuse Guidelines, presenting a six-step model and suggesting principles and actions for cultural competence in elder abuse assessment and intervention.

28. The Elder Abuse Guidelines complete the set of Ministry of Health guidelines on family violence.

Violence Intervention Programme

29. As mentioned, the Family Violence Health Intervention Project commenced in 2001. The project evolved to become the Violence Intervention Programme (**VIP**) and was officially launched in 2007, by the then Minister of Health Hon. Peter Hodson. The VIP included implementation of the Child and Partner Abuse Guidelines in all District Health Boards (**DHBs**). The VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services.

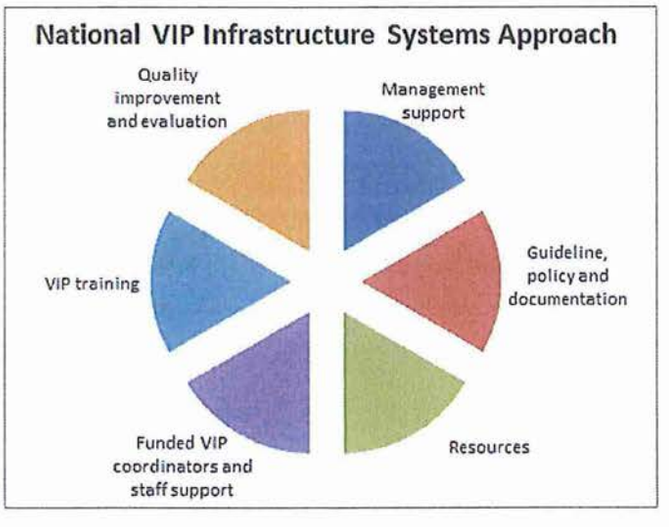
30. Established under the *Public Health and Disability Act 2000* (NZ), DHBs are responsible for providing or funding the provision of health services in their district. There are currently 20 DHBs in New Zealand. Public hospitals are owned and funded by DHBs.

31. The VIP is premised on a standardised, comprehensive systems approach supported by six programme components funded by the Ministry of Health. These components are outlined in the table below:

Component of VIP	Description
The DHB contract service specifications include the employment of a 1.0 FTE DHB Family Violence Intervention Coordinators (FVICs)	The FVIC's key responsibilities include coordinating the programme delivery in the DHB, including ensuring the systems infrastructure is established for the DHB and the clinical services where it is implemented.
The Child and Partner Abuse Guidelines and Elder Abuse Guidelines	The guidelines are outlined above.

Component of VIP	Description
Resources	VIP resources include a Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre website, posters, cue cards, pamphlets and VIP Quality Improvement Toolkit.
Technical advice and support	This is provided by a National VIP Manager for DHBs, National VIP Trainer and biannual national and regional FVIC networking meetings.
National training contracts	The Ministry of Health contract a provider to develop and ensure national training resources are aligned to the Child and Partner Abuse Guidelines. The DHBs are required within the contract service specifications to train to this package and the National VIP Trainer is available to make certain the FVICs are delivering the approved package to the required standard. The Ministry of Health also funds organisations such as Plunket, the New Zealand College of Midwives and Family Planning to train their staff to screen, assess and refer for family violence and child abuse. Further information can be found at: https://nsfl.health.govt.nz/service-specifications/current-service-specifications
External evaluation of DHB family violence responsiveness	The VIP external evaluation project, operating since 2003, provides information to DHBs and the Ministry of Health about the implementation of family violence programmes. Eight evaluations have been conducted to date.

32. In addition to these overall components, the VIP systems approach identifies certain infrastructure required for successful implementation. Each health service should perform a 'systems check' to ensure that all support processes are established, prior to beginning the VIP. The diagram below sets out the infrastructure required for a systemic approach aimed at achieving organisational and attitudinal change:



33. Importantly, each activity depicted is mutually reinforcing. Successful interventions should involve all six components and be implemented in a clockwise sequence. Implementing only one or some of the activities, such as just training or guidelines, has been shown to be ineffectual.

34. There are six designated services that the DHBs prioritise in regard to program rollout, these services are Emergency Department, Child Health, Maternity, Sexual Health, Alcohol and Drug and Mental Health. When the program is implemented it is important to take a service by service approach that there is capacity to provide the critical post-training support that encourages training to be converted to practice change.

Key lessons learned

Infrastructure Systems Approach

35. The infrastructure systems approach has been the core of the VIP program. The Ministry of Health's experience has shown a number infrastructure elements to be key to successful implementation of the VIP in DHBs.

36. Firstly, management support and senior clinician support are critical. In the Ministry's experience senior managers, doctors, nurses, midwifes and other health professionals willing to champion the VIP have made significant differences to the roll out of the program.

37. Second, community partnerships are important. Health services need to work closely with community and family violence services in particular. It has been clear throughout the VIP process that health professionals are not intended to become experts in resolving family violence issues for clients; their role is to undertake the six-step intervention and know which service to make the appropriate referral to. Having clear relationships with partners, and in some instances formalising them (for example, DHBs have a national Memorandum of Understanding between the Police and Child, Youth and Family to respond to serious incidents of partner violence and child abuse and neglect and some DHBs have memoranda with specialist family violence services, such as women's refuges) is vital. Additionally, community agencies are represented on health sector steering groups and training teams to strengthen collaborative working relationships and embed this interagency-interdisciplinary approach.

38. Third, DHBs must have formal internal policies for addressing family violence that align with the Ministry's national Child and Partner Abuse Guidelines. DHBs are also progressing the establishment of policies aligned to the Elder Abuse Guidelines.

39. Fourth, health services require clinical champions and peer support at all levels in each service. Ownership of the VIP cannot simply be led at a senior management level. Analogous to, but different from, clinical supervision, DHBs are required to implement peer support systems which require debriefing of staff after disclosures of family violence, as this is recognised as a practice change that can be emotionally difficult for staff. This peer-support process should ensure that the intervention for victims is appropriate, the staff are supported and in looking after these two groups the organisational risk is minimised.

40. Fifth, resources are important. DHBs have a number of physical resources available to them such as posters, pamphlets, cue cards and community agency directories. VIP coordinators in the health services and the Ministry of Health also provide advice and support at multiple levels.

41. Sixth, DHBs are required to train all clinical staff in both child and partner abuse intervention through initial and ongoing training. Post training support in clinical areas is critical to ensure the training to practice change occurs.

42. Seventh, DHBs are required to undertake clinical audits as part of a quality assurance and improvement process. Audits assess screening rates, disclosure rates and quality of documentation including assessment documentation, and the quality and quantity of referrals to other agencies.

43. Eighth, community agency feedback is essential. DHBs need to seek feedback from community agencies for a number of reasons, including on the quality of referrals, as well as the community's commitment and capacity to respond to referrals received from the health sector. The Ministry of Health has strong relationships with these agencies and in some instances, such as where the implementation of the VIP results in increased demand for services, can assist them by writing letters of support for funding applications to other government bodies.

44. Ninth, trialling programmes is important. The Ministry of Health commenced the VIP in only four of the 20 DHBs. The initial tender response involved 16 DHBs, and the Ministry selected the top four to trial the program. This provided the opportunity to pilot for five years before the VIP was launched nationally.

45. Finally, the infrastructure systems around documentation, training of staff and national evaluation warrant detailed explanation.

Documentation

46. A fundamental recommendation before the VIP is rolled-out to a new service relates to documentation. Appropriate documentation is very important. Health services must have documentation templates for recording whether family violence screenings have in fact occurred and if not, why not. Similarly, all DHBs should have a template for recording family violence disclosures, and if a referral was made. These systems may be either electronic or paper-based and may be separate to or integrated with clinical coding.

47. Documentation templates addressing patient screening for family violence act in two ways. First, they provide an easy and consistent way for staff to record the fact that an intervention has been initiated and/or provided, rather than on an ad hoc basis. Second, they act as a useful reminder to staff to ask the appropriate screening questions.

48. For different health services, creating and implementing appropriate documentation templates will take some trial and error. Each service will need to adapt the process to their own daily practice in order to make sure the process is effective. A service should frequently examine the rates of the screening questions being asked, as well as the number of family violence disclosures. If, for example, a health service has a 100% screening rate but no disclosures, then the quality of the screening needs to be reviewed. The disclosure rate should be at least similar to the rates within the population.

Training staff

49. The Ministry of Health contract with DHBs provides for four hours mandated training for partner abuse intervention and four hours of training for child abuse and neglect intervention, delivered on the same day. Having both components of training delivered on the same day is critical. The training is structured to a national standard by the national VIP trainer. Training aligns with DHB policies, national guidelines and training and audit tools. Core eight hour training, ongoing refresher and in-service training is critical to embedding VIP as business as usual in the designated services. The training provides staff with the knowledge and skills to incorporate family violence intervention into everyday practice. The package content includes the prevalence and

impact of family violence, theory to support practice and the intervention. The training process uses exercises to enable attendees to practice the intervention in a safe and supported environment.

50. One of the most significant learnings from the VIP is that training staff should be the last step in implementing successful family violence programs. Rather than being the key or indeed only feature, training staff should be a component of a broader program. The Ministry of Health's experience is that training alone will not result in changes in practice. An early evaluation undertaken showed there was no change in documentation practices following training. It was not until the family violence documentation template was introduced that changes in practice occurred. Policy agreement on infrastructure systems and championship from the highest levels of management, and in each individual health service, is a fundamental prerequisite to commencing training. Similarly, staff require a significant level of support once they have completed the relevant training to incorporate the learnings from the training into business as usual practice.

51. Importantly, training must be sensitive to the population prevalence of family violence. Many health sector staff will have experienced family violence in their own relationships at some point in their lives (it may be current), and services must ensure any training appropriately recognises this. For example, when training is scheduled the pre-reading introduces the content and details the support processes (such as counselling or referral) available for staff in the event that reading the material raises issues for the staff member. There is also an understanding that training may need to be deferred for a period of time until support can be accessed. In this way, staff can be supported before they are required to attend training and before they are asked to implement the intervention into practice. In addition, training should always be delivered by at least two facilitators; this is best practice as it ensures safe process in the event that an attendee is affected.

52. The VIP involves ongoing funding to DHBs to support this model, recognising that training and systems development is a process of continuing improvement.

Evaluation framework

53. The Ministry of Health set up a national external evaluation framework from the beginning of the VIP. The evaluation was part of the initial tender process. The eight

external evaluations conducted to date were conducted by the Interdisciplinary Trauma Research Centre at Auckland University of Technology.

54. The first evaluation, conducted in 2003/4, provided baseline data on the level of system responsiveness to intimate partner violence and child abuse and neglect. Baseline hospital responsiveness was measured through audits conducted during site visits.

55. The evaluations have used standardised audit instruments to measure hospital family violence programs, dividing these into two sections: partner abuse programs and child abuse and neglect programs. Initially, the instruments examined a number of performance measures including: policies and procedures; physical environment; cultural environment; training of staff; screening and safety assessment; documentation; intervention services; evaluation activities and collaboration. These measures have evolved over subsequent evaluations, but represent all of the structural components the Ministry of Health has recognised as key to staff being able to implement successful programs.

56. Similarly, over time the evaluation framework has moved from on-site audits to self-audits by DHBs with some site visits. The transition to self-audits occurred once the data revealed DHBs were achieving scores of 70 or more in their performance measures. This approach recognises increasing programme maturity across DHBs and supports identification of strengths, weaknesses, opportunities for improvement and prevention of problems. Any DHBs which are not performing well are given additional support, such as a site visit.

57. The latest published evaluation, which was conducted in 2013, outlines in detail the evaluation approach and findings. Attached to this statement and marked '**MH 5**' is a copy of *Hospital Responsiveness to Family Violence: 108 Month Follow-Up Evaluation* dated 2013. A further evaluation has recently been completed and will be released shortly. A further evaluation has recently been completed and will be released shortly.

58. Having this framework in place from commencement has allowed DHBs to track their progress across different elements of the VIP as well as compare themselves with other DHBs. Additionally, the framework was vital in terms of communicating the impacts of the program to Government and the broader community. It has been

helpful to have numeric ways of expressing the incremental growth of systems over time.

59. DHBs have also continued to conduct independent clinical audits using a set of template audit tools provided by the Ministry of Health. Going forward, the Ministry of Health will be implementing snapshot clinical audits, where each DHB takes a sample audit of particular services (e.g. a child health service and a maternity health service). The aim of this process is to have standardised national data.

60. To date, the evaluation framework has been focused on the implementation of infrastructure systems; that is, whether DHBs have put things like policies, training and documentation processes in place. Moving forward, the Ministry of Health will be moving to evaluations focused on the outcomes of the VIP for patients and clients post screening and referral.

Community integration

61. Within DHBs, and the hospitals and community providers (such as general practitioners and midwives) they support, there are variable degrees of knowledge of local community family violence services and initiatives.

62. One of the components of the VIP is for DHBs to have clear referral pathways.

63. In New Zealand, the Ministry of Social Development maintains the Family Services Directory, which is a publically available and searchable online database (http://www.familyservices.govt.nz/directory/). The Family Services Directory lists information about family support organisations and the services/programmes they offer to support New Zealand families. The purpose of the Family Services Directory is to connect people with providers who can help them to cope with common issues and problems. It enables an individual to easily identify all of the services available in their local area. The Family Services Directory includes family violence support services.

64. However, the Ministry of Health expects DHBs to do more than use initiatives like the Family Services Directory. Individual health services are expected to know and keep themselves up to date with services in their local areas and to have a good understanding of the services that are provided by individual agencies, and to develop relationships with them. The Child and Partner Abuse guidelines (at pp35-36) list a range of child abuse and parent support services and emphasise:

'[E]xternal referral agencies are vital in providing support to actual or suspected victims of abuse. It is strongly recommended that you or your agency meet and develop referral relationships with local staff from the organisations here, before commencing use of this guideline.

It is vital that health care providers have knowledge of the people and groups within their local community who possess the necessary knowledge and skills for supporting Maori children and women who are victims of violence.'

65. Best practice is to discuss the referral options and identify the most suitable referral agency. Unless statutory intervention is required, it is then about facilitating this referral by supporting the person to make the call and or making a phone available in a private area. The Ministry supports DHBs and local health services to do this through the VIP Coordinators, as well as resources like lists of referral agencies, patient information sheets and involving key agencies directly in training health sector staff.

66. The Ministry of Health has found that community integration depends on the characteristics of each DHB, the populations they serve and the health services they provide or fund. As such, community integration must be coordinated and personalised to each DHB.

67. The New Zealand Government and the community services sector have a specific focus on multi-disciplinary approaches to addressing social issues. This is about becoming more of a community, and making contacts to address social issues. The New Zealand Government has made it clear that the public service is expected to demonstrate innovation and improvement across a public sector that is connected and collaborative, for example through the Better Public Service Targets (http://www.beehive.govt.nz/feature/better-public-services). In relation to family violence, there is a need to recognise the complexities of intimate partner violence and child abuse and neglect and for government, the health sector and the wider community to be working together.

Current cross agency family violence work

68. In late 2014, the New Zealand Government created a cross-agency Ministerial Group on Family Violence and Sexual Violence (comprising 16 portfolios including, the Ministry of Health), to oversee a whole-of-government approach to addressing family and sexual violence. The Ministerial Group is co-chaired by the Minister of Justice

and Minister of Social Development and is committed to reducing family violence and sexual violence and keeping victims safe.

69. On 29 July 2015, the Government publicly released the work programme of the Ministerial Group (https://beehive.govt.nz/webfm_send/68). The work programme will create a new plan of action that will allow government to make better decisions about government spending to ensure we can make the biggest differences in people's lives. It is framed around stopping family violence from occurring, reduce the harm caused by family violence and breaking the cycle of family violence. Activity within the work programme includes a review of New Zealand's family violence related legislation, which is currently the subject of a public consultation process, an internal New Zealand Police change programme to improve the way police respond to family violence, and the development of a family violence system framework led by the Ministry of Social Development, which includes shared definitions, investment rationale and framework, outcomes framework and indicators, client centred data, workforce framework and research and an evaluation agenda. This work aligns with a range of work the Government has undertaken to protect the most vulnerable New Zealanders, such as the Children's Action Plan and the Gangs Action Plan.

Other observations

Early years interventions

70. There has been an increasing focus in the New Zealand health sector on interventions in the early years of a child's life and on supporting vulnerable mothers, fathers and their babies. Three DHBs are currently running the Maternity Integration pilots and 16 DHBs currently have some form of group to address early years health issues, including family violence. These groups provide a forum where women can be referred into early intervention services. The groups are led by senior midwives, and include child protection coordinators, maternal mental health workers, paediatric social workers, maternity carers, Child, Youth and Family Social Workers and police.

71. There are five key referral pathways and criteria: family violence; alcohol and other drugs; mental health; previous interaction with child protection and lack of social support. The goal of these groups is to intervene early with the family and in doing so reduce the likelihood that a statutory intervention (e.g. child protection) will be required. All of the support workers are involved in drafting an agreed intervention plan, which is also invaluable should statutory intervention be required, because the

records includes details of the plan as well as the communication required between services.

72. The Hawkes Bay DHB has a thoughtful and well-constructed model for multi-agency inter-sector collaboration, role setting and outcome measurement in the form of their Women Child and Youth Continuum Strategic Framework. The Continuum incorporates robust Maori involvement and includes clear target setting and monitoring frameworks. The operational models include a Maternal Wellbeing and Child Protection Multi-Agency Group, Family Violence Intervention Programme, Postnatal Adjustment programme and Fostering Security programme.

Screening

The New Zealand Government has made a conscious decision to implement routine family violence screening for women over 16 years of age who interact with the health system. Men are screened on suspicion of family violence, but not routinely. The evidence around routine screening is mixed, but does not support routine screening for men. The evidence is strong that health services are not causing harm by routinely screening women for family violence, and screening men on suspicion. The Child and Partner Abuse Guidelines recommend identification of child abuse and neglect based on signs and symptoms. A recent Cochrane review found that screening was likely to increase identification of intimate partner violence in healthcare settings and does not seem to cause harm in the short term.

Community awareness campaigns

73. The implementation of the VIP needs to be understood in the context of the 'It's not OK' campaign, coordinated by the Ministry of Social Development. The campaign, launched in 2007, is a community-driven behaviour change campaign to reduce family violence in New Zealand. Its goal is to change attitudes and behaviour that tolerate any kind of family violence, and to engage and support the whole community in preventing and responding to family violence. The 'It's not OK' campaign recognises that the whole community has a role to play.

74. The campaign has been evaluated a number of times. These evaluations, along with an overview of the campaign, contacts and resources are available on the campaign website (http://www.areyouok.org.nz/).

75. The Ministry of Health sees these types of public awareness campaigns as critical to supporting the role of the health sector in responding to family violence.

Information sharing

76. Finally, the Ministry of Health has continued to engage with privacy issues in responding to family violence. Information sharing and the role of privacy legislation has been an ongoing focus when establishing programs such as VIP. There are two notable initiatives, outlined below, which may be of interest to the Victorian Royal Commission into Family Violence.

77. The New Zealand Privacy Commissioner has released guidance resources for multi-agency teams (in which DHB professionals participate). This guidance outlines an 'escalation ladder', to assist teams to decide whether to share personal information of families and vulnerable children. Attached to this statement and marked '**MH 6**' is a copy of *Sharing personal information of families and vulnerable children A guide for inter-disciplinary groups*.

78. In June 2015, a number of New Zealand government agencies signed an Approved Information Sharing Agreement (**AISA**) for improving public services to vulnerable children. Created in the context of the *Vulnerable Children Act 2014* (NZ), and pursuant to Part 9A of the *Privacy Act 1993* (NZ), the AISA authorises the disclosure of information between the parties to identify vulnerable children, assess their needs and inform the appropriate service response. Attached to this statement and marked '**MH 7**' is a copy of the AISA dated 29 June 2015.

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Dr Pat Tuohy

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Ms Helen Fraser

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Ms Miranda Ritchie

Dated: 11 August 2015