A Common Approach to Understanding Family Violence Risk Assessment and Management

Submission to the Ministry of Justice

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Contact

MARILYN HEAD, BA, DIP TCHG, MSC, SENIOR POLICY ANALYST

DDI 04 494 6372 OR 0800 283 848 | E-MAIL **MARILYNH**@NZNO.ORG.NZ **|** www.nzno.org.nz

NEW ZEALAND NURSES ORGANISATION | PO BOX 2128 | WELLINGTON 6140

About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on your consultation document *A Common Approach to Understanding Family Violence Risk Assessment and Management* ("the document").

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the College of Child and Youth Nurses, College of Primary Health Care Nurses, Mental Health Nurses Section, Women's Health Section, Gerontology Nurses Section, the Board, Te Rūnanga o Aotearoa, and professional nursing, policy, legal, and research advisers.

3. This submission is also informed by previous consultations on a number of related documents to which we have responded - for example, the Family Violence Law Review in 2015 and Family Violence Guidelines in 2016; many aspects of the Children's Action Plan implementing the Vulnerable Children's Act 2014; and various clinical, service and workforce documents concerning mental health, addiction, sexual violence, elder abuse, and workplace violence where family violence is a relevant factor. (See http://www.nzno.org.nz/resources/submissions).

Consultation

4. Notwithstanding the fortnight's extension, we object to the consultation process and timeframe which are not consistent with either regulatory or best practice guidelines. We draw your attention to commonly used and accepted guidelines for consultation in:

    - Section 7 of the Local Government Act which stipulates a minimum of four weeks and a maximum of three months;
    - the Ministry of Health consultation guidelines for District Health Boards relating to the provision of health and disability services (2002);
    - the Cabinet Manual which advises that "Effective and appropriate consultation is a key factor in good decision making, good policy, and good legislation" and requires "realistic time frames"; and
    - the National Institute for Health and Care Excellence (NICE) *Community engagement: improving health and wellbeing and reducing health inequalities guidelines* which "covers community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations. The guideline complements work by Public Health England on community engagement approaches for health and wellbeing."[1].

5. We also recommend to your attention a recent article on consultation published in the March edition of the Specialist (Keene, 2016)[2] which highlights the risks of poor consultation.

General comments

6. As frontline health practitioners, nurses frequently come into contact with a person at risk of, or experiencing violence, and are able to refer and/or initiate timely and appropriate interventions aimed at the prevention, early detection/screening and, where appropriate, reporting of abuse or violence.

7. Nurses' experience of the assessment and management of violence between government agencies points to a disjointed and siloed

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[1] https://www.nice.org.uk/guidance/ng44
[2] Lyndon Keene. Consultation or 'Public relations'. *The Specialist*, Association of Salaried Medical Specialists. Mar 16 2016, p55-56. Retrieved August 2106 from http://www.asms.org.nz/wp-content/uploads/2016/03/10985-The-Specialist-Mar16-WEB-1.pdfpp5- 6.

approach, and one-way, uncoordinated communication which frustrates the best efforts of all, is unsafe, and ineffective.

8. We therefore **welcome** this document. Government organisations need to have a common approach to family violence focused on safety and prevention/reduction of harm. Ie one policy, system and knowledge framework (training, education, regulation) that encompasses core and specialist areas with robust, transparent protocols for sharing information, referral/follow-up, and appropriate treatment/action.

9. We are pleased that this is generally the approach adopted in the document, but have concerns with the document's

    - lack of acknowledgement of te Tiriti o Waitangi;
    - narrow context of family violence; and
    - overemphasis on specialist justice and family violence services.

10. We draw your attention to the WHO's ecological approach to violence prevention[3] which we suggest is particularly useful in the context of developing a common approach across many sectors.

11. We strongly recommend the document references underlying values including commitment to te Tiriti o Waitangi and human rights.

12. NZNO supports the document's primary focus on safety, and also harm reduction/prevention through screening, which fit well with the six assessment and intervention steps of the Ministry of Health's national Violence Intervention Programmes (VIP).

13. NZNO's view is that health must be embedded as central to a common approach to the management of family violence because:

    - health status is affected by violence;
    - health can be a causal factor of violence; and
    - all people engage with health services throughout life (eg through universal child health services, mental health, addiction, and gerontology services).

14. Health services thus offer the opportunity for early identification and clinical intervention/treatment/referral to reduce and prevent harm at every stage of the journey of both victims and perpetrators.

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[3] http://www.who.int/violenceprevention/approach/ecology/en/

15. The Health sector is well positioned to lead the development of a first step of a common approach to the assessment and management of family violence. There is a robust national programme already in place which includes training of staff across all District Health Boards (DHBs) and, ideally, Justice, Social Development, Tamariki Oranga and other sectors would work with Health to adopt a national coordinated programme.

Workforce

16. Family violence is a societal issue, strongly linked to many aspects of the social determinants of health, though this is only superficially covered in the document.

17. The ability to deal with family violence safely and constructively is strongly dependent on the capacity and capability of the workforce.

18. It is not enough to 'integrate' services and systems, and facilitate workforce flexibility. There must be robust assurance of workforce competence through appropriate regulation, education and training to ensure safety and accountability.

19. In this respect we note the disparate training and regulation of social support and social workers. Some of the latter are registered, but none are, as yet, regulated. In general, most social workers employed outside the Ministry of Social Development or DHBs, ie by NGOs are not registered.

20. Education and training must be relevant and strongly linked to employment. There is little point in developing appropriate training and qualifications if employers do not value them, or do not have to employ qualified people.

21. In addition, for this framework to improve the lives of those concerned, it will need to be overtly prioritised and valued within the various social and health systems, ie resourced properly.

22. We trust that amidst the plethora of new strategies, initiatives and 'investment' approaches that the government has signalled, particularly in the comprehensive reforms outlined in the "Investing in Families and Children" programme, that a *robust* (ie informed by evidence) common approach to understanding *and responding to* the assessment and management of violence, will be implemented (NZNO italics).

Recommendations

23. In general NZNO **supports** a common approach to the assessment and management of family violence and **recommends** that you:

- **amend** the draft document to include**:** a statement of values and acknowledgment of te Tiriti o Waitangi and the culturally specific context of Aotearoa New Zealand**;** a broader description of the context of family violence that recognises violence as the outcome of interaction among many factors at different levels; and a more robust investigation of gender politics/power and control themes in relation to family violence;

- **agree** that Health is central to all aspects of family violence and should be embedded in a common approach to the assessment and management of violence;

- **agree** that Health should play a leading role in the development of a common approach because it has an established regulated workforce able to screen and assess; the opportunity for early intervention and lifelong service connection; health practitioners are trained to refer appropriately to clinicians and other agencies eg social services, police; and there are robust protocols for identification, privacy , sharing information etc.;

- **agree** that an enabling and inclusive regulatory framework that is robust enough to ensure that, regardless of whoever and however services are provided (ie govt provided, or purchased from communities, NGOs etc.), there are quality assurance standards that facilitate the development and utilisation of a safe, flexible workforce; and

- **note** the need for further work on elder abuse, and on violence in the workplace, a significant issue for health workers (particularly mental health and Emergency Department workers) that is connected to family violence.

24. Our responses to the consultation questions follow.

DISCUSSION

Part 1: a framework for assessing and managing family violence risk

1. Do you agree with how we have described family violence and its dynamics?

From a justice perspective, it may be, but it is too narrow for ‘a common approach’. We suggest describing a broader context that recognises violence as the outcome of interaction among many factors at different levels as described in the World Health Organisation’s ecological framework for the global campaign on violence prevention (see fig 1).

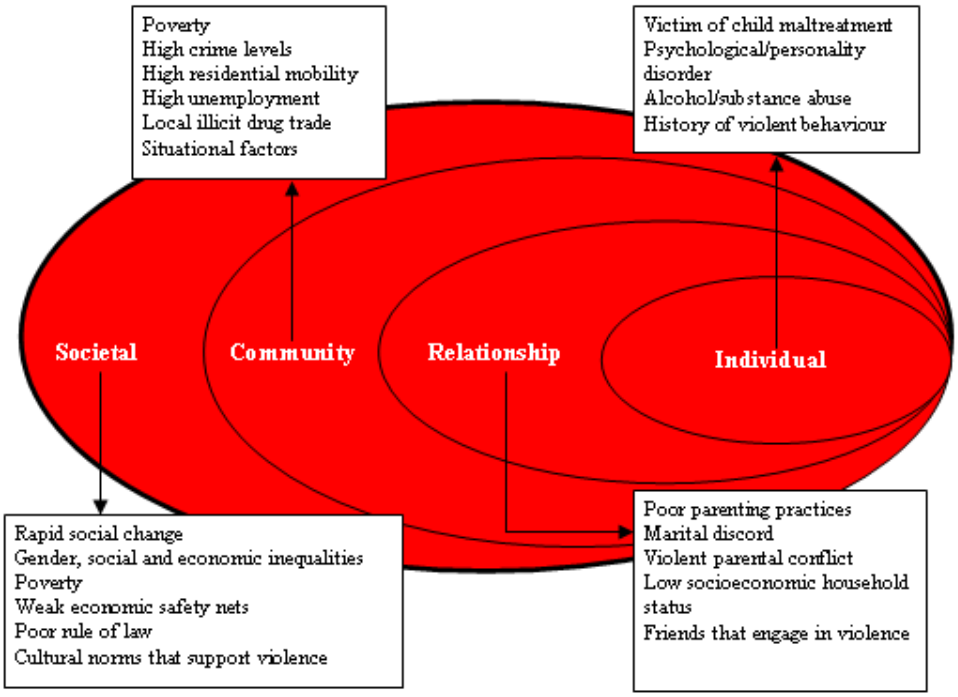

Figure 1 The Ecological Framework, WHO
http://www.who.int/violenceprevention/approach/ecology/en/index.html

There are a number of gaps ie:

- no clear values statement;
- lack of discussion of gender politics/power and control themes within family violence;
- the cultural context of victims and perpetrators is addressed minimally – te Tiriti o Waitangi is not mentioned; there are no services related to Māori and Pacific listed in the safety concerns list at the beginning of the document; .
- an over emphasis on specialist justice and FV services, without canvassing the capacity of this workforce or considering utilisation of other frontline staff who are already working with individuals and families affected by violence e.g. practice nurses, Plunket, women's health, ED and mental health and addiction; and
- no discussion of “trauma informed approaches”. This model of service provision requires an acknowledgement of the effects of trauma from the first point of contact.

Given the high rates of family violence in Māori and Pacific populations, it would be helpful to provide more direction around culturally safe ways to approach family violence. Cultural competence/safety is a required competency for all health, and many other professionals.

Responsibility - we agree that the perpetrator is responsible, but acknowledgment of the inter-generational nature of some family violence and the socio-cultural context of family violence is also necessary. Identifying patterns is critical, and underlines the need for early intervention, robust identification and information sharing.

Wider health issues – these need to be more comprehensively identified. The "trauma informed approach" to mental health and addiction service provision is widely accepted and should be mentioned. Equity, the impact of structural discrimination, and the effects of violence on productivity should/could also be canvassed in this context.

Gender/power issues need to be examined in more depth and detail.

2. Do you see any benefit of discussing other forms of family violence within the framework? If so, what forms are most relevant to New Zealand?

The description is adequate in coverage of major problems. Sexual violence including incest could be more explicitly identified.

We suggest a more integrated model than the linear pictograph on page 18 could better illustrate a common approach since many services/factors overlap eg Pharmac's 'factors for consideration' (p7) [4].

We agree with the three guiding practice principles:

- victim safety;
- perpetrator behaviour change and accountability; and
- collective action.

However, we cannot support the statement on perpetrator change:

> Accountability for family violence lies with the perpetrator and should never be attributed to a 'bad relationship'; achieving victim safety requires abusive behaviour to be contained challenged and changed.

This completely ignores <u>support</u> for change, which will not occur on its own. The statement should include access to appropriate health assessment and

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[4] PHARMAC. *Operating policies and procedures of the Pharmaceutical Management Agency* ("PHARMAC") retrieved September 2016 https://www.pharmac.govt.nz/assets/opp-2016-08-3rd-ed-rev.pdf

treatment. Inadequate access to health care is a significant component of violent behaviour. It is not acceptable to ignore the impact of undiagnosed conditions which can be painful and expensive to treat, the effect of alcohol and drug addiction, Fetal Alcohol Syndrome Disorder (FASD) etc., lack of assessment of risk, mental health issues and the stresses associated with poverty as these are all factors linked to family violence.

The principles statements should be extended to assert the rights of both victims and perpetrators to access to health assessment and care. This is what will connect services across sectors and disciplines.

Screening and identification of family violence

1. Do you have feedback on this discussion of screening for family violence?

The goal of screening is to identify individuals and families who need further assessment and some form of intervention to reduce the likelihood of further violence. It is also to provide an appropriate service (e.g. trauma informed approach) for the client/patient/service user and help reduce the negative impacts arising from the violence.

Screening, even on sensitive issues such as family violence, has become much more embedded in everyday nursing practice for in many services – Family Planning, Plunket, Mental Health, Public Health nursing etc. which have robust training standards and expectations. The context, ie a therapeutic relationship with a health professional, is an important factor in establishing trust, and that can also depend on the role and duties of the professional. Eg Nurses dealing with highly vulnerable children, who are at risk, or victims, of family violence sometimes feel that they are better able to establish a relationship because, unlike social workers, they are unable to uplift children. (Conversely, this can be a source of frustration when repeated referrals of acutely at-risk children are not acted upon). Public health nurses also have the statutory right to examine children without the consent of a parent or caregiver in the case of suspected violence and play an important role in keeping children safe.

An ethical concern with screening is whether it will improve outcomes for the person being screened. Screening, unless it is universal, can be a form of structural discrimination and the document should reference this. An amorphous reference to identification and “some form of intervention” is totally inadequate; there needs to be a clear understanding of the process and expected action.

In this respect nurses have ample experience of the repeated failure of social service agencies to act upon referrals, and the significant impact on both consumers and practitioners when services are not adequately planned for and resourced. The recent diverse and experimental development of children’s teams, as part of the Children’s Action Plan implementing the 2014 Vulnerable Children’s Act is a case in point. The

children's teams were implemented with virtually no extra funding in the naïve and unrealistic expectation that the Lead Professional (often a public health nurse) would case manage and coordinate services for highly vulnerable children young people and their families *in addition to* their day to day work, when almost triple the FTE is required[5]. Nurses have been left with less capacity to manage core work with vulnerable children (ie early intervention to reduce harm) and in addition are responsible for caring for highly vulnerable children.

The risks here, and elsewhere are compounded by appropriate referrals to other services, particularly CYFS, not being acted on and there being no protocols or capacity to share information; nurses were not aware of the Vulnerable Kids Information System (ViKI) before it was piloted, much less consulted about it, and the lack of opportunity to provide meaningful feedback/input has meant, not surprisingly, a less than useful information sharing system.

In speaking to NZNO's submission on the recent Children, Young Persons, and Their Families (Advocacy, Workforce and Age Settings) Amendment Bill, two senior nurse members gave evidence of repeated failure to act on referrals in dire and pressing circumstances, and of the lack of communication between social and health services. Unless there is a two way communication; explicit criteria for referral, intervention, escalation; and the ability to act on those criteria, there is no point in screening.

We also suggest that screening should be any time a woman is admitted to hospital. We acknowledge that it is often difficult to screen in an ED situation, but if a woman is admitted there should be time. All pregnant women should be screened at 'booking', along with other routine screening midwives conduct.

2. What makes it difficult for you to conduct effective family violence screening?

Nurses' biggest concern is the fear of "uncovering" something they cannot handle or are unable to do anything about, and fear losing the relationship that keeps families engaged with their services.

This a legitimate concern because:

- they often lack time;

[5] Eg Waikato DHB allowed 1 FTE across 23 public health nurses for this work, and later found it required 2.8FTE; The Report of a Survey analysis of the Christchurch Children's Team stated "Supervision is expected to be provided through the usual channels LPs already have within their home agency – this is noted in the Memorandum of Understanding between the employer and Children's Team".

- sometimes lack knowledge and skill in the screening process - Note NZNO's Position Statement on Interpersonal Violence[6] and the need for appropriate training;

- there is a lack of institutional support e.g. clinical or professional supervision to keep the practitioner safe; and

- referrals are not acted upon because other services have different risk criteria and thresholds for action.eg an expert nurse assessment and acute referral of a vulnerable child was not acted upon because the 41 reported instances of domestic violence the child had had been exposed to were deemed "low level violence" and therefore the child was not "immediately at-risk"; no further action was indicated.

3. In your area, are there services available to take referrals to conduct risk assessment, following screening?

Nominally, there are services in all areas but they are not well connected with health and use different, or no accredited risk assessment model such as the Manitoba Risk Assessment model widely used in child health.

4. What needs to be done to support effective screening to occur, either within the framework or as part of efforts to implement it?

Training opportunities at all levels, and in both academic and employment settings should highlight the need for screening and ensure everyone is aware who is responsible for screening, when and what the follow up procedures are. Cross sector referrals should be possible, but also require some training /education to ensure appropriate referral.

We suggest that because of the generalist role and ubiquity of nurses who are regulated health professionals working in all health settings across all Aotearoa New Zealand, training should be incorporated into the curriculum for all nursing and midwifery students.

5. Would you find the provision of a screening tool based on best available, local and international evidence valuable in your practice? If so, what are your needs?

Yes. Should be able to be integrated within comprehensive assessment processes.

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[6] NZNO. 2012 Position statement on Interpersonal violence. Retrieved Sept. 2016 http://www.nzno.org.nz/Portals/0/publications/Interpersonal%20Violence,%202012.pdf

Risk assessment

1. Do you have feedback on this discussion of risk assessment?

Appears to be evidence based.

What support is needed to ensure that risk assessment is effective? (For example, the development of information sharing protocols between organisations, addressing barriers to accessing appropriate and timely risk management services, the development of mechanism/s to collate risk information from across agencies?)

Yes - these examples are all necessary for the process to work.

Do you have guidance, tools or practice approaches within your organisation that align with this framework, or could help to develop the proposed approach?

This risk assessment process is narrowly aimed at justice and specialist family violence services. There are multiple mental health nursing guidelines and tools which could be inclusive of a family violence risk assessment process. The overemphasis on specialist services raises the potential risk of 'patch protection' and suboptimal use of the workforce. Specialist family violence NGOs rely upon government contracts to survive so have an incentive to control as many aspects of the process as possible.

Risk management

Questions 1- 5

This risk management process is primarily aimed at justice and specialist FV services. If families are not within the justice system, the agencies involved need to have clear processes for rapid referral.

Often nurses are the frontline professionals working most closely with people in crisis who may have a greater sense of trust and security in disclosing these very personal experiences to nurses. There needs to be an essential level of risk assessment in the role of the nurse. Nurses need to have an understanding of legal processes such as protection orders. They also need an understanding of safety plans as used within justice and FV services.

PART 2: DEVELOPING A COMMON APPROACH IN PRACTICE

There are particular safety risks with screening potential perpetrators of family violence and specific training is needed to conduct this activity. It would be helpful to have examples for the type of training which would be considered appropriate and safe.

The pre-screening and screening process is described effectively.

Generally the role of health care providers is underrepresented, with the narrow focus on Justice and specialist family violence services under-representing. The nature of nursing is such that the victims of family violence are very likely to have nurses as early contacts e.g. ED, mental health acute services. P.34 mentions "some health care providers"- nurses in primary, secondary and tertiary services are in a very strong position to play a frontline role in this area, certainly in screening, initial risk assessment and referral. In order to effectively address this issue whilst maintaining safety, nurses need a very good understanding of privacy and related legislation/regulation eg Crimes Amendment Bill and Vulnerable Children's Act 2014.

The issue of protection of health workers in relation to the emerging inter-sectorial information sharing needs to be addressed. There is an expectation that it is acceptable for a health worker to disclose information to other sectors as long as it is in the interests of vulnerable people e.g. victims, children. Inter-sectorial groups in the family violence area will include Police, Corrections, CYFS, health, education, family violence NGOs etc. These groups are variously trained and regulated and all have different codes of conduct, ethical codes and professional and employment boundaries. Existing and potential conflicts and barriers need to be addressed to ensure a workable common approach that does not put these workers at risk of violating professional standards.

Nurses are frequently in the position of having valid concerns about information disclosure and self-protection that are not well understood in NGO interdisciplinary and inter-sectorial team discussions. Consequently they, along with other DHB representatives and regulated practitioners, are thought "difficult" or even obstructive about the disclosure of important information. Conversely, Public Health and Plunket nurses find it difficult to obtain information or follow up referrals because there are no two way information sharing protocols. There is a potential for workers to be caught in a Catch 22 situation when new vulnerable children regulations insist that practitioners are responsible for following up and ensuring a child's safety even when they have no way of doing so. These are important practical and technical issues which must be carefully and comprehensively examined in consultation with government agencies, employers, regulators, professional and union bodies, to ensure a common approach to the assessment and management of family violence. They are not issues which can continue to be ignored.

An example of a joined up approach is that being used in Nelson with Safeguarding Children: http://safeguardingchildren.org.nz/. This approach is cross sector including police, health, social care, education, community members etc and is proving extremely successful across the community.

Marilyn Head
Senior Policy Analyst